MIEC

The Exchange

JANUARY 2013 ISSUE 3

INSIDE

MIEC *The Exchange* is published by Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland CA 94618. Articles are not legal advice. Reproduction with permission. © 2013

Pain Medication Management: Are you prepared?

Dear MIEC Policyholders:

Mismanagement of narcotics to treat pain is a HOT claims topic across the nation. The FDA and state medical boards alike are pursuing physicians who have been reported as overprescribing opioid drugs allegedly contributing to patient death. Here at MIEC we have experienced a significant influx in pain medication management claims resulting in high indemnity payments. We've also encountered criminal cases filed against policyholders, previously a rare occurrence among our physician owners. The reality is that as a medical professional, you could be charged with overprescribing narcotics or even criminally charged for the death of a patient who abuses drugs.

MIEC is here is help our owners reduce their risk as they try to provide standard of care pain medication management to their patients. To that end, we have dedicated this issue of *The Exchange* to the topic of pain medication management. Other timely topics include: MIEC's partnership with risk management foundation CRICO Strategies, patient satisfaction surveys, and a HIPAA refresher. We hope you find the recommendations and resources helpful.

And to all of our valued policyholders, we wish you a Happy New Year!!

Best regards,
Claudia Dobbs
Loss Prevention Manager

Pain Medication Management: Are you prepared?

As reported by an Institute of Medicine panel in July 2011, more than 116 million Americans struggle with chronic pain nationwide. Medical expenses and lost productivity linked to chronic pain cost the United States as much as $635 billion annually.[1] According to the Centers for Disease Control and Prevention (CDC), fatal poisonings from opioid overdoses

1 O'Reilly K. "States try more aggressive RX opioid control." Amednews.com. Posted October 17, 2011.

tripled to nearly 14,000 nationwide between 1999 and 2006 and opioid-related emergency department visits doubled to more than 300,000 between 2004 and 2008.[2]

Perhaps even more disturbing for physicians than these enormous statistics are the number of doctors who have been convicted in criminal matters for the over-prescription of painkillers. Reuters replicated research conducted by James Filkins, a doctor and lawyer who has written about the criminal prosecution of physicians, and tallied over 37 reported criminal cases between 2001 and 2011. Most recent cases against physicians are for over-prescribing painkillers and other controlled substances, such as the case of Michael Jackson's physician Dr. Conrad Murray.[3] US Drug Enforcement Administration (DEA) information also suggests a similar trend. For 2003, the DEA reported 15 physician arrests that resulted in convictions and by 2008, the most recent year of comprehensive data, the number had grown to 43.[4]

Failure to adhere to risk reduction strategies

Experts recommend the close oversight of patients who receive opioid analgesics for chronic non-cancer pain (CNCP), especially those with increased risk of misuse (e.g., patients with risks factors such as age <45, drug or alcohol use disorder, tobacco use, and mental health disorder). In a study published in the *Journal of General Internal Medicine* online February 24, 2011, researchers Joanna Starrels, MD, MS, et al. hypothesized that physicians employ opioid risk reduction strategies more frequently in higher risk patients; however, this was not borne out

2 Ibid.

3 Baynes T. "Update 1 – More US doctors facing charges over drug abuse." www.reuters.com. Posted September 14, 2011.

4 Ibid.

In a Nutshell:

- Implement your state medical board's *Guidelines for Prescribing Controlled Substances for Pain*. **(See discussion below.)**
- State licensing boards can, and will, impose discipline on a physician for negligent prescribing practices, even in cases in which the physician feels that he or she is appropriately providing chronic pain management. A medical board can take licensure action against a physician for either an act of gross negligence, or repeated acts of simple negligence.
- Be familiar with "black box" warnings for all controlled substances that you prescribe. *Register at PDR.net to receive current FDA-approved drug alerts and recall drug information electronically*. **(See the Case Study below.)**
- Develop and adhere to risk reduction strategies, including: require urine drug screens, conduct regular face-to-face office visits to evaluate patients' response to opioids and risk of misuse, follow a pre-defined refill schedule (i.e., restricting refills of opioids prior to expiration of the previous prescription), and clearly document your treatment plan and management thereof.
- Have patients sign a Medication Management Agreement. **(See Figure 1.)**
- Consider seeking a pain management consultation for patients whose medication management becomes complex, or those who present with few clinical symptoms. Carefully document physical findings (or lack thereof) and refer such patients to a pain management specialist or a psychiatrist.

by the study results.[5] Strategies include: urine drug testing, regular face-to-face office visits to evaluate patients' response to opioids and risk of misuse, and adhering to a pre-defined refill schedule (i.e., restricting refills of opioids prior to expiration of the previous prescription).

The study, time framed from January 1, 2004 to April 30, 2008, was a retrospective cohort using administrative data from eight urban or suburban primary care practices within the University of Pennsylvania Health System. All practices shared an electronic medical record. Participants were age 18 and older who completed three or more visits to a primary care practice, were on long-term opioids (defined by three or more opioid prescriptions written at least 21 days apart for six months), and were treated for CNCP. The study aimed to: (1) evaluate the frequency of urine drug testing, regular office visits, and restricted early refills; and (2) to examine the association of patient risk factors for opioid misuse with receipt of each of the three strategies.[6]

Findings:[7]

- While being treated with long-term opioids, fewer than 10% of the cohort (approximately 1600 primary care patients) received any urine drug testing, only half had regular office based visits, and 23% received more than one early opioid refill.
- Patients with increased risk of opioid misuse were more likely to have urine drug testing. However, it was still infrequent with less than 25% of the patients with three or more risk factors having any urine drug test. These patients were also more likely to receive more than one early refill, but their office-based monitoring was no greater than for patients without risk factors for opioid use. The study revealed lax monitoring.
- Only half of patients met the minimum recommendation frequency of office-based monitoring of patients on long-term opioid therapy. The lack of face-to-face encounters represents missed opportunities for physicians to examine responses to treatment, propose alternative treatments when response is inadequate, detect side effects, and assess for misuse.
- Researchers found that 23% of the cohort received more than one early opioid refill. Of greater concern, patients with a current or past drug use disorder were more likely to receive early refills.
- The study supported recommendations for a more standardized approach to opioid risk reduction including: using screening tools to identify patients at increased risk of misuse; a treatment agreement that stipulates the necessity for regular office visits, restricted early refills and urine drug testing; and team-based care to track patients' visits, prescriptions, progress, and aberrant drug taking behaviors.

A Case Study: Be familiar with the black box warning

(The facts have been changed to protect the identities of the plaintiff and defendant.)

Allegation: *Negligent prescription of Duragesic patches (fentanyl) resulting in death of a 45-year-old male from overdose.*

The Board-certified internal medicine physician saw the patient, a 45-year-old disabled firefighter, one time only on September 2. The patient's brother

5 Starrels JL, Becker W, Weiner M, Li X, Moonseong H, and Turner B. "Low Use of Opioid Risk Reduction Strategies in Primary Care Even for High Risk Patients with Chronic Pain." Journal of General Internal Medicine. Published online February 24, 2011.
6 Ibid, p. 958.
7 Ibid, p. 962.

Policyholders give advice

Dean J. Nickles, MD (Associated Internal Medicine Medical Group, Oakland, CA) recommends:

" Physicians who treat chronic non-cancer-related pain should get a number of medical disciplines involved such as neurology, psychiatry/psychology, and pain management. Also develop a pain contract that includes: only one physician will prescribe the patient's narcotics; only one pharmacy will fill the patient's prescriptions; and medications will not be refilled if lost."

Steven Una, MD (Infectious Disease and MIEC Board of Governors member) advises:

" Maintaining an open bi-directional cooperative relationship is critical to managing pain. Many physicians do that through contracts, although one would hope that the contract is only a formality, and that trust would drive the physician-patient relationship."

Gary Okamoto, MD (Physical Medicine and Rehabilitation and MIEC Board of Governors member) advises:

" In assessing a patient's response to treatment, identify and monitor a set of specific activities of daily living (ADLs), work tasks, or physical capabilities. Data points on a patient's self-reported disability and function can suggest pertinent questions about the effectiveness of one's pain management."

referred the patient to the internist's office where he was to undergo a physical exam; chief complaint: severe pain, multiple sites. The patient had recently relocated to the area and did not have a copy of his medical records. As a result the internist did not have an opportunity to review them prior to the examination. The patient relayed that he sustained multiple fractures in a work-related accident as well as a subsequent motor vehicle accident in 2000. He reported fractures to his right arm, severe injuries to both shoulders with neck and low back pain. His medical history included long history of chronic pain, migraine headaches, degenerative joint disease, depression, and fibromyalgia. The patient had been treated with methadone and other pain medications for many years.

The patient expressed frustration with the number of different pain medications he had taken over the years with little relief. At the time of the visit, the patient claimed to have run out of his medications about a week prior to the visit and was in severe pain. His undocumented medication history included: Methadone 10 mg twice a day supplemented with high dosages of Demerol and Morphine Sulfate which the physician estimated to total 300-350 mg daily. In addition, the patient had taken Flexeril 10 mg three times a day, Cymbalta 30 mg twice a day, and Soma 350 mg as needed.

Based upon the conversation about the patient's daily pain medication regimen, the physician prescribed Duragesic patches, 50 mg per hour to be used every 72 hours. The physician recommended a pain management consultant and tried to refer the patient to a specialist, but the patient refused. There was no documentation of an informed refusal discussion in the single chart note. According to the internist, the patient's brother, who accompanied the gentleman to the visit, agreed to help control the number of patches the patient used.

On September 7, the patient's brother found him dead. He had one Duragesic patch in place and five patches were missing with three remaining in the box. The patient allegedly used seven patches within four (4) days. The autopsy revealed that the patient died from acute poisoning from a combination of fentanyl and duloxetine. The fentanyl drug level was 19.6 ng/mL (upper normal limits is 3 ng/mL) and the duloxetine concentration was 285 ng/mL.

This case had multiple issues impairing the physician's defense:

- No documentation of a patient history (e.g., no medical records to review; no clear understanding of the patient's pain management history or documentation thereof).
- The physician was not familiar with the black box warning for the patches, which read in part,

  "DURAGESIC® should ONLY be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to DURAGESIC® 25 mcg/h. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid."
- No evidence of an informed refusal discussion.

As a result the case was settled in the high six figure range and defense costs totaled upwards of $150,000.

Guidelines for Prescribing Controlled Substances for Pain

Adopted unanimously by the Medical Board of California in 1994 and revised in 2007
http://www.mbc.ca.gov/pain_guidelines.html

History/Physical Examination

A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

Annotation One: The prescribing of controlled substances for pain may require referral to one or more consulting physicians.

Annotation Two: The complexity of the history and physical examination may vary based on the practice location. In the emergency department, the operating room, at night or on the weekends, the physician and surgeon may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the physician and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.

Treatment Plan, Objectives

The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

Annotation One: Physicians and surgeons may use control of pain, increase in function, and improved quality of life as criteria to evaluate the treatment plan.

Annotation Two: When the patient is requesting opioid medications for his/her pain and inconsistencies are identified in the history, presentation, behaviors to physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

Informed Consent

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

Periodic Review

The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Annotation One: Patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care.

Annotation Two: Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

Consultation

The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist.

In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion.

Annotation One: Coordination of care in prescribing chronic analgesics is of paramount importance.

Annotation Two: In situations where there is dual diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to physicians and surgeons who prescribe controlled substances for intractable pain provided the physician complies with the requirements of the general standard of care and California *Business and Professions Code* sections 2241 and 2241.5.

Records

The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

Annotation One: Documentation of the periodic reviews should be done at least annually or more frequently as warranted.

Annotation Two: Pain levels, levels of function, and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver, and objective findings by the physician.

Compliance with Controlled Substances Laws and Regulations

To prescribe controlled substances, the physician and surgeon must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances

prescriptions. Physicians and surgeons are referred to the *Physicians Manual* of the U.S. Drug Enforcement Administration and the Medical Board's *Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons* for specific rules governing issuance of controlled substances prescriptions.

> ***Annotation One:*** There is not a minimum or maximum number of medications which can be prescribed to the patient under either federal or California law.
>
> ***Annotation Two:*** Physicians and surgeons who supervise physician assistants (PAs) or nurse practitioners (NPs) should carefully review the respective supervision requirements.
>
> Additional information on PA supervision requirements is available at www.pac.ca.gov.

PAs are able to obtain their own DEA number to use when writing prescriptions for drug orders for controlled substances. Current law permits physician assistants to write and sign prescription drug orders when authorized to do so by their supervising physician for Schedule II-IV. Further, a PA may only administer, provide or transmit a drug order for Schedule II through V controlled substances with the advanced approval by a supervising physician for a specific patient unless a physician assistant completes an approved education course in controlled substances and if delegated by the supervising physician. To ensure that a PA's actions involving the prescribing, administering, or dispensing of drugs is in strict accordance with the directions of the physician, every time a PA administers or dispenses a drug or transmits a drug order, the physician supervisor must sign and date the patient's medical record or drug chart within seven days. (Section 1399.545(f) of Title 16, *Code of Regulations*)

NPs are allowed to furnish Schedule III-V controlled substances under written protocols.

Postscript

While it is lawful under both federal and California law to prescribe controlled substances for the treatment of pain including intractable pain — there are limitations on the prescribing of controlled substances to or for patients for the treatment of chemical dependency (see Sections 11215-11222 of the California *Health and Safety Code*). In summary, a physician and surgeon must follow the same standard of care when prescribing and/or administering a narcotic controlled substance to a "known addict" patient as he or she would for any other patient. The physician and surgeon must:

- Perform an appropriate prior medical examination;
- Identify a medical indication;
- Keep accurate and complete medical records, including treatments, medications, periodic reviews of treatment plans, etc; and,
- Provide ongoing and follow-up medical care as appropriate and necessary.

The Medical Board emphasizes the above issues, both to ensure physicians and surgeons know that a patient in pain who is also chemically dependent should not be deprived of appropriate pain relief, and to recognize the special issues and difficulties associated with patients who suffer both from drug addiction and pain. The Medical Board expects that the acute pain from trauma or surgery will be addressed regardless of the patient's current or prior history of substance abuse. This postscript should not be interpreted as

a deterrent for appropriate treatment of pain.

Alaska guidelines: Alaska's Medical Board lacks a position statement on the use of controlled substances and the management of pain; however, the Alaska Board of Nursing adopted a guideline in 1996 patterned after the Federation of State Medical Board's guideline. For a copy: http://commerce.alaska.gov/occ/pub_nursing_opinions/APRN_Advisory_Pain_Management.pdf

Hawaii guidelines: In 2006, the Hawaii Board of Medicine adopted its pain management guidelines, which are patterned after the guidelines established by the Federation of State Medical Boards. For a copy: http://www.painpolicy.wisc.edu/domestic/states/HI/mbgl.pdf

Idaho guidelines: The Board has adopted criteria when evaluating the physician's treatment of pain, including the use of controlled substances. The full document is available at: http://www.painpolicy.wisc.edu/domestic/states/ID/idmbguid.htm

Resource for state guidelines: http://www.medscape.com/resource/opioid/

Loss Prevention Recommendations

In addition to the "In a Nutshell" guidelines (See page 2), consider the following when treating chronic non-cancer pain patients. Fine-tune your index of suspicion and proceed cautiously with patients you suspect are drug-seeking:

- Know your state regulations as they pertain to the prescription of controlled substances and pain management. For example, California physicians licensed on or after January 1, 2002, must complete a CME course in pain management and end-of-life care within four years of initial licensure or by the second renewal date, whichever occurs first. All California physicians are required to complete twelve (12) hours of CME on this topic as part of the minimum of one hundred (100) hours of CME required every four years. The states of Alaska, Hawaii, and Idaho do not have such a requirement.
- Regularly access your state's prescription monitoring program.
  - California physician prescribers may request a Patient Activity Report (PAR), a printout that discloses the patient's prescribing history found in the CURES data system. (See http://ag.ca.gov/bne/trips.htm for more information.)
  - Alaska physicians can learn more about Alaska's prescription monitoring program at http://pmp.relayhealth.com/AK/index.htm.
  - Hawaii physicians can contact the state's Department of Public Safety, Narcotics Enforcement Division at 3375 Koapaka Street, Suite D-100, Honolulu, Hawaii 96819, phone: 808/837-8470, for more information about the prescription monitoring program.
  - Idaho physicians can learn more about Idaho's prescription tracking program through the Board of Pharmacy at http://bop.idaho.gov. Contact Program Information Coordinator Teresa Anderson at teresa.ande
  - rson@bop.idaho.gov.
- Seek continuing medical education resources for further training and education about

pain management. For example, the book *Responsible Opioid Prescribing: A Clinician's Guide* by Scott M. Fishman, MD, (Chief of the Division of Pain Medicine and Professor of Anesthesiology at UC Davis) is recommended by the Federation of State Medical Boards and physicians can earn 7.25 AMA PRA Category 1 Credits for reading the publication and completing the post-test.

- Consider designing progress note templates dedicated to pain management. If you use an electronic record, the software should allow you to develop such a template. **(See Figures 2 and 3.)**
- Be wary of patients who vigorously request specific medications. Be kind but skeptical.
- Write prescriptions legibly and ensure that there is no room for alteration of your order (i.e., write out numbers; indicate "no refills;" be careful of placement of the zeros and decimal points, etc.).
- Ensure that patients do not have access to your prescription pads. Do not "pre-sign" prescription pads.
- Alert staff to inform you if patients' behaviors are radically different in the reception area from what they are in the exam room.
- Alert patients, in advance and in writing, of the best time to call to request a refill of their medications (i.e., several days before they are due to run out; on weekdays rather than weekends, etc.). If they request an untimely refill (i.e., too early if it was taken properly), refill only enough medication to last them until they can come to the office for an appointment, a good faith exam, and a re-evaluation of their condition. Do not deviate from your written refill policy except for rare, unusual circumstances in which you feel confident of the patient and the clinical necessity to do so.
- If you believe that you have been duped by a patient and/or a patient is making unrealistic demands for medications with potential abuse consequences, you may call the MIEC Claims department for advice on how to proceed.
- If in doubt about your ability to identify and treat drug-seeking patients, consider a refresher course in pain management to strengthen your clinical and philosophical positions on the subject.
- Consider withdrawing from care from patients you believe are attempting to obtain prescriptions from you in the absence of clinically-determined necessity. (See "How to discharge a patient from your medical practice," MIEC's Managing Your Practice #2.)

Our thanks to MIEC Board members Drs. Gene Cleaver, Robert Margolin, Gary Okamoto, and Steven Una for their counsel on the contents of this article.

Medication Management Agreement

The decision to use opioid (narcotic) medications was made because of my specific condition or because other treatments have not helped my pain. Because Dr. ***(your name)*** is prescribing such medication for me to help manage my pain, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible (please initial each numbered item):

_____ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.

_____ 2. I understand that the main treatment goal is to improve my ability to function by reducing pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.

_____ 3. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be fully determined and that treatment may change while I am under Dr. ***(your name)***'s care. I understand, accept, and agree that unknown risks may be associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances are made, and will make appropriate treatment changes. I also know there may be other non-opioid options for my pain control.

_____ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from Dr. ***(your name)***. To do so may endanger my health and/or our physician/patient relationship. The only exception is medication prescribed while I am admitted to a hospital.

_____ 5. I understand the following refill policy:

(for example)

a. The daily dose may not vary. The weekly/monthly dose must remain constant.
b. Medications will not be refilled early, even if they have been lost.
c. Medications will not be refilled on Fridays, weekends, or holidays.
d. Medications will not be refilled by other physicians.

_____ 6. I agree to use ***(name of pharmacy)*** pharmacy, located at ***(address and telephone number of pharmacy)*** for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.

_____ 7. I agree to **keep all scheduled appointments**.

_____ 8. At each visit, Dr. ***(your name)*** will evaluate me for pain relief, side effects, function, and abnormal behavior (anything indicating addiction). I understand that evaluation may also include recommended lab work to monitor my medication's efficacy. I must keep Dr. ***(your name)*** fully informed of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.

Figure1

This sample Medication Management Agreement contains elements that promote patients' understanding of their role and responsibility in their pain management treatment process. This sample agreement should be adapted to reflect the policies and procedures of individual medical practices. Some items appear in bold-faced type for emphasis. Items in bold and italic type may be formatted according to physicians' preferences. Conduct hand-offs at bedside, involving the patient and the patient's family. Clearly document patient and family understanding of the discussion.

_____ 9. Dr. ***(your name)*** may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, Dr. ***(your name)*** may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.

_____ 10. You have my permission to discuss my ***(medical condition/medication management)*** with my spouse or significant other. ***(Optional: include space to write in name of spouse or significant other.)***

_____ 11. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 12. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

_____ 13. I have been fully **informed** by Dr. ***(your name)*** regarding the potential psychological **dependence** on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

_____ 14. **I understand that if I fail to comply** with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

I have read this agreement. I fully understand the consequences of violating this agreement. Dr. (your name) has answered my questions and I agree to the terms of the agreement.

Patient name: _____

Patient signature and date: _____

Witness signature and date: _____

☐ Copy given to patient

Some physicians may wish to include additional statements in their medication management agreements, such as:

- I will take my personal medications as directed, no more and no less. I will not tamper with prescribed medications by cutting, crushing or by any other means altering the intended dose of medication. I will not take the medications by any other than the directed route of administration (oral, trans-dermal, or rectal).
- I will not adjust the medications by myself. I will discuss with Dr. ***(your name)*** any change in dosage I feel I need. Some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. As a result of other treatment modalities or the natural course of my disease process, my pain may decrease. My medication doses will have to be adjusted by Dr. ***(your name)***.
- I will not hoard my medications. If I am able to control my pain with fewer narcotics, I will inform Dr. ***(your name)***.
- I am responsible for keeping track of the amount of medications left on my prescription and will plan ahead for arrangements to refill my prescriptions in a timely manner so I will not run out of medications.
- I understand that I must make necessary arrangements to alert Dr. ***(your name)*** of my need for a refill five (5) working days before they run out.

Figure 1 cont.

Pain Management Progress Note

(First visit)

Patient Name: _____ DOB: _____

Allergies: _____

Current medications: _____

Vital Signs: _____ Temp_____ BP _____ P_____R_____Ht. _____Wt._____ BMI_____

CC: _____

History/Physical Examination:

Current Pain scale: 1 2 3 4 5 6 7 8 9 10

Prior hx of pain treatment [medication; interventional injection(s)]: _____

_____

Prior hx of substance abuse: _____

_____

Past medical history (underlying or coexisting diseases or conditions?): _____

_____

Family history: _____

Social history: _____

Review of data (lab, imaging, old records): _____

_____

ROS: (Physical and psychological function?)
General appearance:
HEENT:
Cardiac:
Lungs:
Abdomen:
Extremities:
Neuro:

PE: (Medical indication for controlled substance use or for interventional pain management? Both?)

Medical decision making:

Figure 2

Assessment:

Treatment Plan Checklist:

☐ Medication Management Agreement signed (_____)
Staff initials

☐ Lab test: _____

☐ Imaging test: _____

☐ Referral to (list specialty and reason): _____

☐ Medications prescribed (☐ checked "black box" warnings):

(1) _____

(2) _____

(3) _____

(4) _____

☐ Interventional pain management:

(1) _____

(2) _____

(3) _____

☐ Informed consent discussion:

_____

_____

_____

☐ RTC _____

Figure 2 cont.

Pain Management Progress Note

(Follow up visit)

Patient Name: _____ DOB: _____

Allergies: _____

Current medications: _____

Vital Signs: _____ Temp_____ BP _____ P_____R_____Ht. _____Wt._____ BMI_____

CC: _____

History/Physical Examination:

Current Pain scale: 1 2 3 4 5 6 7 8 9 10

Interim history:

_____

_____

_____

_____

Medication effectiveness/ineffectiveness:

_____

_____

_____

_____

Injection effectiveness/ineffectiveness:

_____

_____

Review of interim data:

_____

_____

PE:

Figure 3

Assessment:

Treatment Plan Checklist:

☐ Pain relief (control of pain?): _____

☐ Improved physical relief (increase in function? Improved quality of life?): _____

_____

☐ Improved psychological relief: _____

☐ Urinalysis required before next visit:_____

☐ Medications prescribed, refilled (checked "black box" warnings) _____

(1) _____

(2) _____

(3) _____

(4) _____

☐ Interventional pain management:

_____

_____

_____

☐ Informed consent discussion:

_____

_____

_____

☐ Referral to (list specialty and reason): _____

☐ RTC _____

Figure 3 cont.

From the Claims Department

Claims Q & A Corner

It's no secret that state licensing boards have disciplined physicians for excessive or inappropriate prescribing of narcotic pain medications, but isn't that only in cases of gross negligence or criminal behavior?

Not necessarily — state licensing boards can, and will, impose discipline on a physician for negligent prescribing practices, even in cases in which the physician feels that he or she is appropriately providing chronic pain management.

For example, the Medical Board of California can take licensure action against a physician for either an act of gross negligence, or repeated acts of simple negligence. This means that, if a physician's prescribing practices are investigated and the Medical Board expert reviewers determine that more than one patient was managed in a negligent manner, the Medical Board can impose discipline on a physician.

In the fiscal year ending in 2011, the Medical Board of California took licensure action against 30 physicians for inappropriate prescribing. Of those actions, 10 cases involved mandatory probation; five cases resulted in license surrender, and another 10 involved license suspension or revocation.

In response to a revised Model Policy issued by the Federation of State Medical Boards (FSMB), in 2003 the Medical Board of California revised its own policy to address the perceived under-treatment of pain. Physicians were required to recognize and adequately treat pain, and they were disciplined for failing to prescribe pain medications when indicated.

There are early signs that the pendulum could be swinging in the opposite direction.

As noted in this newsletter, there have been numerous recent instances of physicians being criminally prosecuted, as well as disciplined, for prescribing excessive amounts of narcotics to patients on a chronic basis. There have been several national news articles on the public health threat posed by overuse of narcotics, as well as the mounting federal crackdown on overuse and abuse in the healthcare industry.

In its 2012 annual report, the FSMB announced that it has launched a major initiative to address opioid misuse and abuse. The FSMB cited data from the CDC indicating that deaths secondary to prescription painkillers have more than tripled since 1999, and that nearly 500,000 ER visits in 2009 were due to the misuse or abuse of opioid pain medications. The initiative aims to reduce opioid abuse while preserving patient access to necessary pain medications.

The FSMB is again revising its Model Policy on opioid pain management to address these dual goals. It recently convened two workgroups comprised of state medical board executives, medical directors, board members, and pain management experts to update its Model Policy for the Use of Controlled Substances for the Treatment of Pain, and the Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office. The new policy is expected to be published in 2013.

Current pain management policies already require physicians to minimize the potential for abuse and diversion of narcotic pain medications, and to recognize and prevent the use of them for other than legitimate medical purposes, while still recognizing and treating legitimate pain. Physicians have, and will, be disciplined for failing to recognize when chronic pain management poses a risk to the patient. However, once the new FSMB Model Policy is issued, the Medical Board of California, and state licensing boards in general, are likely to step up their enforcement of physicians who overprescribe narcotic pain medications for chronic pain patients. Physicians will be asked to walk an increasingly fine line in the treatment of pain.

As part of this article on pain management, we have included the California Medical Board's *Guidelines for Prescribing Controlled Substances for Pain*, strategies patterned after those established by the Federation of State Medical Boards. The states of Alaska (via the Board of Nursing), Hawaii, and Idaho have similar guidelines. We encourage all policyholders to implement their state's opioid prescribing guidelines in an effort to promote patient safety, provide quality medical care, and decrease their liability exposure, both criminal and civil, when prescribing controlled substances.

MIEC and CRICO Strategies Partnership

"From a statistical standpoint, malpractice data reflect a small body of information, so small that it defies statistical significance. For all the press that is gets, malpractice is still a relatively rare event when considered against the denominator of the total amount of healthcare given on a daily basis. However, these data are very rich and serve as a valuable guide to where the vulnerabilities are in healthcare."

Robert Hanscom, VP, CRICO/RMF Strategies[8]

For over 35 years Medical Insurance Exchange of California (MIEC) has worked with policyholders to help them mitigate the risk of malpractice litigation. Staff and outside consultants have closely examined MIEC's claims data and used it to guide us as we seek to effectively safeguard our physician owners. Although the leading allegations (for each insured specialty) can be readily identified, information to help physicians affect risk is limited. In other words, like most regional malpractice insurers, MIEC's database is not large enough to draw broad-stroked conclusions about the drivers of malpractice loss for MIEC policyholders.

Accordingly, claims data from outside of MIEC has been evaluated to provide leadership additional insight into predictors of future loss. The Physician Insurers Association of America's (PIAA) Data Sharing Project is such a resource, a claims database to which 20+ physician-owned professional liability carriers have contributed for the past 25 years. PIAA has tabulated, in part: general allegations against physicians in most specialties; severity of injury; associated issues that affect litigation outcome; associated personnel named in the claims; and, average indemnity as well as defense costs.

Evidence-based data to improve care

As much as MIEC is interested in evidence-based claims data to help identify malpractice loss, we as a physician-owned

8 PIAA, "Interview," Physician Insurer, Fourth Quarter 2010, page 45.

professional liability carrier also seek to support our policyholders in their own efforts to recognize and reduce systemic risk, promote patient safety, improve patient satisfaction, and advance the quality of the healthcare they provide. MIEC saw an opportunity to do just that by partnering with an organization that uses its claims data to implement what it calls "actionable intelligence."

CRICO Strategies, the Harvard medical community's risk management foundation, has collected, deep coded, and analyzed Harvard's claims data for more than 30 years for the purpose of affecting change within the Harvard system. The 140-person Cambridge firm has assembled one of the nation's largest databases (more than 200,000 claims) and used the data to identify the most common opportunities for improvement in five major areas: emergency medicine, surgery, ambulatory care, obstetrics and electronic medical records. Data is used to: review questions on clinical judgment; evaluate the effect of breakdown in communication between all healthcare providers; pinpoint where injuries occur and why; and much more. Data also has been benchmarked within the Harvard medical community to provide comparative statistics between peers, a critical capability in this service because it allows MIEC to be much more targeted in addressing potential sources of malpractice allegations.

And the data mining has paid off! Where US hospitals average 12 malpractice claims per 100 physicians covered every year, doctors represented by Harvard's malpractice carrier, CRICO, average 2.3 claims.[9]

Within the last 10 years, CRICO Strategies opened its analytical capabilities to Stanford, to California's UC system, and to several regional and national malpractice carriers. MIEC was among the first to invest in this capability. Jeffrey Driver, Chief Risk Officer at Stanford University Medical Center believes in the power of the CRICO data, "CRICO's malpractice data-crunching is the gold standard in the world." Using CRICO's data and addressing the risk areas it identified, Driver reports that Stanford has reduced its malpractice claims 25% over the past five years, and is saving $3.2 million a year in insurance costs. [10]

The goal of MIEC's partnership with CRICO Strategies

By partnering with CRICO Strategies, MIEC plans to make available to our policyholders more comprehensive analysis and insight into their claims data in an effort to assist them as physicians work to ascertain and affect the greatest areas of risk within their specialties. Comparative data between peers also will allow MIEC owners to improve upon identified deficiencies within their own practices and learn from errors prevalent among physicians in the peer community. With CRICO Strategies' data mining also come resources that policyholders and their staff can access to positively affect areas that need attention. Specialty-specific analyses are under development. In due course this data will be available to policyholders upon request.

Patient Safety Advice from CRICO

Watch Where You Step

by Jock Hoffman, Managing Editor for Patient Safety, CRICO

Diagnosis-related errors are alleged in about 21 percent of all malpractice claims and suits filed from 2006–2010. The majority of these (56 percent)

9 Restuccia, Paul, "Data takes scalpel to malpractice lawsuits," Boston Herald (MA), September 30, 2012.

10 Ibid.

occur in the Emergency Department and other outpatient settings. Analysis of the nine major steps along the typical diagnostic path pinpoints where patients are most vulnerable to diagnostic errors, and where physicians and their staffs need to concentrate their patient safety focus.

Step	% of Diagnosis Cases		
	All	Outpatient	ED
1. Patient Seeks Care Access, scheduling, or waiting issues impede the patient from raising a relevant health problem, or delays him or her from seeking care for a recognized problem.	3%	3%	6%
2. History, Physical, and Evaluation of Symptoms The patient's history is not fully recorded or updated; the physical examination is absent or inadequate; the patient's complaints or symptoms are not thoroughly addressed.	46%	36%	70%
3. Test Ordering A narrow diagnostic focus—or reliance on a chronic condition or previous diagnosis—impairs the ordering of appropriate tests or imagings.	63%	60%	70%
4. Test Performance Ordered test/imaging is not performed, or specimen is mislabeled or mishandled.	4%	3%	4%
5. Test Interpretation Report of findings are determined to be incomplete or inaccurate; abnormal findings not ruled out.	37%	43%	29%
6. Test Results Communication Test result is not received (or not reviewed) by the ordering physician, is not reviewed in a timely manner, or is not communicated to the patient.	10%	11%	10%
7. Physician Follow Up with Patient Findings are not communicated to the patient, follow-up screening is not arranged, or follow up is not documented.	12%	15%	8%
8. Referrals/Consults Coordination of care involving referrals to specialists (or consults) is not adequately managed, or identification of the physician responsible for ongoing care is unclear.	29%	31%	31%
9. Patient Compliance Patient fails to adhere to the follow-up plan, including appointments and treatment regimen.	7%	10%	4%

Based on 1,907 diagnoses-related cases drawn from CRICO's CBS malpractice database.

Managing these steps (and others) across a full panel of patients is taxing to even the best systems, the best technology, and the best of memories. Identifying opportunities to avoid key pitfalls along the diagnostic path is an invaluable asset for your patients and your practice.

Recommendations for reducing the risk of a delayed or missed diagnosis…or an allegation of such an error:

History & Physical

- Elicit critical information using templates with built-in prompts.
- Study the patient's health history (including family history) and current status to identify those at risk.
- Conduct a thorough physical examination.
- Update patient and family history during each visit.

Test Ordering

- Consider specific risk factors and necessary tests.
- Discuss screening options and preference with the patient.
- Consider atypical presentation and age/gender risk factors.

- Embed decision-support tools (algorithms, guidelines, etc.) into your practice workflow.
- Generate a differential diagnosis—regardless of the situation.
- If the diagnostic plan fails to resolve the patient's symptoms, alter the clinical approach.
- Consider peer consultation for persistent complaints and repeat visits.
- Clarify (for the patient) the rationale for recommended tests/imaging, its importance, and how they should follow up.
- Include all relevant clinical information to assist the radiologist, pathologist, etc., in completing the requested test.

Test Interpretation

- Conduct audits, peer reviews.
- Consider duplicate reads.
- Require periodic evaluation and refresher courses.
- Referrals/Consults
- Establish responsibility for coordinating care with the patient and specialty physicians.
- Provide specialists with the rationale for the referral/consult (and relevant clinical information).
- Establish an office-based process to ensure tracking and reconciliation of critical referrals.
- Implement a process to follow up with patients who fail to complete referrals as ordered.
- Establish a mechanism to ensure that reports are communicated to the referring physician.
- Confirm physician review/receipt of critical referrals prior to filing reports.

To whom do you want your patients to talk when they are concerned about their care: You or the government?

As reported by The New York Times (9/23/12), the government has drafted a plan that encourages patients to report medical errors, mistakes and unsafe practices by doctors.

"The Obama administration is field-testing a new reporting system encouraging patients to report medical mistakes and unsafe practices by medical providers. As part of this system, patients reporting "mistakes" would answer these queries if a mistake is perceived to have been made. Patients would report a caregiver did not: 1) communicate well with the patient or the patient's family; 2) didn't respect the patient's race, language, or culture; 3) didn't care about the patient; 4) was too busy; 5) didn't spend enough time with the patient; 6) failed to work with other caregivers; 7) were not aware of care received elsewhere. I find these questions subject, open to various interpretations and an open invitation to make easier the work of malpractice lawyers".[11]

Measuring the patient experience: The values and benefits

At MIEC, we believe that the need to monitor, review and improve patient satisfaction is more important than ever. We know that patients place high value on the interactions they have with their physicians. They care about the communications that take place and about the care and services provided. Moreover, patients who have good rapport with their physicians are less likely to sue them when treatment problems develop than those who lack such rapport. These are compelling reasons for measuring patients' satisfaction with the care and treatment provided. This article examines the value and benefit associated with measuring

11 Reece, R. (2012, 09 23). [Web log message]. Retrieved from http://medinnovationblog.blogspot.com/2012/09/hospital-and-airplane-safety-problem.html

patient experience and shares a sampling of survey measurement tools currently available to you. It is the first of a two-part series about the process of improving the patient experience in your practice.

Why measure patient experience?

- **To effectively manage the challenges.** Over time, successfully managing a physician practice has become more challenging. The demands imposed by regulatory oversight, technology mandates and increased overhead continue to grow while reimbursement rates and margins decrease. Additionally, physicians are now being asked (by both public and private entities) to measure patient experience while simultaneously working to ensure staff satisfaction and productivity. While seemingly burdensome, if you have the right strategies (e.g., a patient satisfaction survey, practice management tools and techniques, staff and referring physician measurement assessments) you will gain valuable information and data which can then be used to guide performance improvement efforts that will help to ensure strong physician-patient relationships.

- **To gather and act on vital data about aspects of care that patients and providers deem valuable.** Patient satisfaction is a potent deterrent to litigation. Patients and their families/caregivers are often the most knowledgeable informants about their experiences with care. Surveys can be used to identify what patients and providers alike have identified as determinants of a "good" provider visit. These include: ease of scheduling appointments; availability of information; communication with clinicians; responsiveness of clinic staff and coordination between care providers. These same factors, if effectively addressed, can increase patient satisfaction, decrease physician liability, ensure more patient referrals and reduce patient defection and damaging word-of-mouth advertising.

How to measure patient experience?

There are a myriad of tools available to measure patient satisfaction. Both public and private organizations now provide survey tools. Below are two examples:

- **The Clinician and Group Practice Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS):** Promulgated by the Center for Medicare and Medicaid Services (CMS), this survey is a product of the Agency for Healthcare Research and Quality (AHRQ) CAHPS program, which is a public-private initiative to develop and maintain standardized surveys of patients' experiences across the continuum of care. The CG-CAHPS survey asks patients to report on their experiences with the healthcare services they received during their visit to your office.

  There are various initiatives supporting the use of the CG-CAHPS survey for physician offices and clinics. For example, California's five-year Section 1115 Medicaid Waiver, which went into effect in November of 2010, created the Delivery System Reform Incentive Program, a federal pay-for-performance initiative that is among the first of its kind in the nation. One of the requirements of the Incentive Program is that all California public hospital systems must begin collecting and reporting data on the patient experience in ambulatory care.

  The initiative uses specific survey questions from CG-CAHPS.

While CMS has not yet mandated the use of the CG-CAHPS survey, it is important that you have a basic understanding of the survey components. Items within the survey instrument can be used to create measures of patients' perceptions of care, including: scheduling appointments and healthcare when needed; physician communication; courtesy and helpfulness of office staff, and overall rating of the doctor. The Survey asks patients to report on and rate their experiences with a specific primary or specialty care provider and that provider's practice. The surveys currently available include: a 12-month survey (adult and child); expanded 12-month survey with patient-centered medical home items (adult and child); and visit survey (adult and child). Each questionnaire contains approximately 37 questions that encompass a standard set of core items that must be administered. Below is a question from the Adult Visit survey:

During your most recent visit, did this provider explain things in a way that was easy to understand?
1.Yes, definitely 2.Yes, somewhat 3.No

For more information about the CG-CAHPS survey you can access the AHRQ website at http://cahps.ahrq.gov/clinician_group.

- **SurveyVitals:** 9G Enterprises Inc. offers a dynamic, user-friendly option to measure patient satisfaction. SurveyVitals provides patient, physician, employee, referring co-treater and peer-to-peer feedback, in addition to reporting and awareness tools that will help your practice improve. The Web-based tool allows you to monitor the patient experience with real-time alerts (which empowers you to intervene and fix a problem in real time), detailed reporting modules and best practice resources. The instrument also includes a dashboard function that reports real-time results in a readily accessible format that affords you a "bird's eye" view of your practice. You have the ability to see perceptions of your performance against established benchmarks and you are able to obtain near-real-time feedback on patient perceptions on various aspects of practice management (e.g., wait times in both reception and examination room). This type of information provides the impetus to take action and improve your patients' experience. For additional information about SurveyVitals, visit their website at www.surveyvitals.com.

No matter what your motivation is to measure patient satisfaction, and however you choose to measure it, make sure that you use the data to improve aspects of your practice and patient care. By proactively collecting and acting on patient satisfaction data, your practice can embark on meaningful quality improvement efforts that will enhance your business acumen, benefit your patients, and help reduce your liability.

In part two of this article, we will help you capitalize on the data you collect by exploring quality improvement tools and techniques that you can implement to improve patient satisfaction in your medical practice.

Our thanks to MIEC Board member Steven Una, MD, for his counsel on the contents of this article.

Have you revisited your HIPAA policies and procedures lately?

The Office for Civil Rights (OCR) on behalf of the Department of Health and Human Services has fined a five-physician cardiology group in Phoenix, Arizona, $100,000 for failing to comply with the HIPAA Privacy and Security Rules, making this the first small practice to be fined a civil monetary penalty for failing to comply with the federal privacy and security regulations.

The OCR launched an investigation after a complaint was filed alleging that the practice was posting surgery and appointment schedules on an Internet-based calendar that was publicly accessible. Further investigation found that the practice failed to implement adequate policies and procedures (P&Ps) to protect patient information; failed to document that it trained employees on HIPAA Privacy and Security Rules; failed to identify a security official within the practice and conduct a risk analysis (required by the Security Rule); and failed to obtain any business associate agreements for its Internet-based e-mail and scheduling services.

MIEC's Loss Prevention Department has encountered many physician practices that do not appear to be HIPAA-compliant. In some cases, the P&Ps originally implemented have not been updated since the Privacy and Security Rules went into effect in 2003 and 2004, and do not meaningfully address the ways in which patient information is used in the practice currently. In many cases, practices seem to be unaware that the HIPAA Security Rule exists and has its own requirements, separate from the Privacy Rule. If you have not updated your HIPAA policies and procedures lately, we recommend that you do so. The Loss Prevention Department can assist you with compliance resources.

- HIPAA compliance requires privacy and security measures that meaningfully address the way patient information is used in your practice today; this may have changed over time.
- Privacy and security policies should adapt and grow, just as your medical practice adapts and grows with respect to the kinds of patient information you use, store and transmit, the purposes for which information is used, and the technologies involved. The designated Privacy Officer and Security Officer (possibly the same person) should evaluate HIPAA compliance on an ongoing basis and update P&Ps and training as necessary.
- Staff members should be trained annually on HIPAA compliance P&Ps.
- Do you now use patient information for research or marketing purposes? This must be reflected in your Notice of Privacy Practices.
- Have you begun seeing minor patients since your P&Ps were first implemented? If yes, are you and your staff familiar with HIPAA laws around minors and parents/guardians? Do you have policies and training to reflect this?
- Many practices seem to be unaware that the HIPAA Security Rule requires that covered entities conduct and document a risk assessment covering specified administrative, technical, and physical safeguards. For more information, visit http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html
- Are you using new technologies to store or transmit patient information that were not in use during your initial Security Rule risk assessment?
- Even if you don't think patient information is being used in new ways, you should update your policies and procedures and training to address whether and/or how patient information can be used in connection with e-mail, texting, social media, laptops, tablets, thumb drives, etc., even if only to specify that patient information is not to be used in these ways.
- Documenting your good-faith efforts to comply with the HIPAA Privacy and Security rules, and diligently updating P&Ps as necessary, are even more important in the context of the HITECH Act's data breach notification requirements. Your efforts to protect patient information can impact whether and how much you are fined for a breach of protected health information.
- MIEC policyholders now have DataGuard coverage to assist with assessing and handling potential data breaches: http://www.miec.com/Default.aspx?TabId=67#dataguard
- For more information on HIPAA and HITECH compliance, visit www.miec.com/RESOURCES/HIPAA_MATERIALS.aspx. You must log in to access these helpful materials. For log-in assistance, contact your underwriter at 800/227-4527.

How to reach MIEC

PHONE:

Oakland Office: 510/428-9411

Honolulu Office: 808/545-7231

Boise Office: 208/344-6378

Outside: 800/227-4527

FAX:

Main Oakland Fax: 510/654-4634

Honolulu Fax: 808/531-5224

Boise Fax: 208/344-7903

E-MAIL:

Lossprevention@miec.com

Underwriting@miec.com

Claims@miec.com