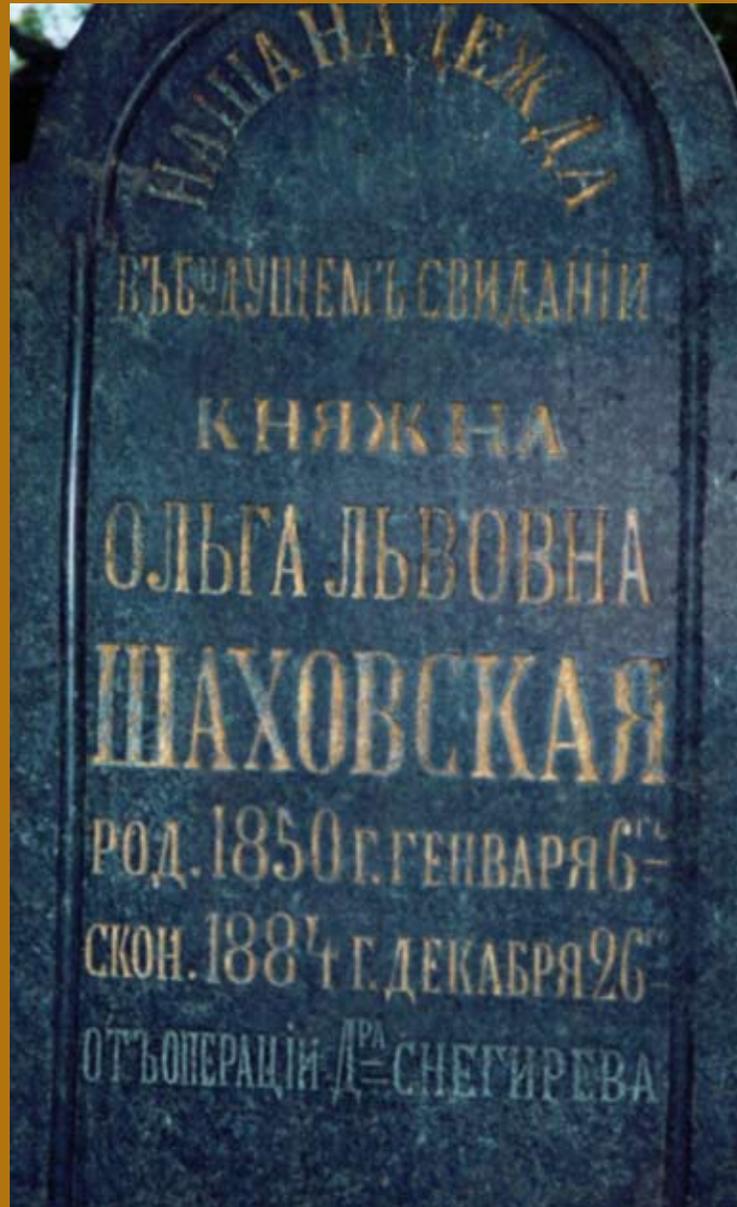


Medicine  Health
RHODE ISLAND



Judicial Enforcement

We're not LIKE A Good Neighbor,
WE ARE
The Good Neighbor Alliance



Specializing in Employee Benefits since 1982

Health Dental Life Disability Long Term Care
Pension Plans Workers' Compensation Section 125 Plans



The Good Neighbor Alliance Corporation

The Benefits Specialist

Affiliated with

**RHODE ISLAND
MEDICAL SOCIETY**



**RIMS-INSURANCE
BROKERAGE
CORPORATION**

401-828-7800 or 1-800-462-1910

P.O. Box 1421 Coventry, RI 02816

www.goodneighborall.com

UNDER THE JOINT
EDITORIAL SPONSORSHIP OF:
The Warren Alpert Medical School of
Brown University
Edward J. Wing, MD, Dean of Medicine
& Biological Science

Rhode Island Department of Health
Michael Fine, MD, Director

Quality Partners of Rhode Island
Richard W. Besdine, MD, Chief
Medical Officer

Rhode Island Medical Society
Gary Bubly, MD, President

EDITORIAL STAFF

Joseph H. Friedman, MD
Editor-in-Chief

Sun Ho Ahn, MD
Associate Editor

John Teehan
Managing Editor

Stanley M. Aronson, MD, MPH
Editor Emeritus

EDITORIAL BOARD

Stanley M. Aronson, MD, MPH

John J. Cronan, MD

James P. Crowley, MD

Edward R. Feller, MD

John P. Fulton, PhD

Peter A. Hollmann, MD

Anthony E. Mega, MD

Marguerite A. Neill, MD

Frank J. Schaberg, Jr., MD

Lawrence W. Vernaglia, JD, MPH

Newell E. Warde, PhD

OFFICERS

Gary Bubly, MD
President

Nitin S. Damle, MD
President-Elect

Alyn L. Adrain, MD
Vice President

Elaine C. Jones, MD
Secretary

Jerry Fingerut, MD
Treasurer

Vera A. DePalo, MD
Immediate Past President

DISTRICT & COUNTY PRESIDENTS

Geoffrey R. Hamilton, MD
Bristol County Medical Society

Robert G. Dinwoodie, DO
Kent County Medical Society

Rafael E. Padilla, MD
Pawtucket Medical Association

Patrick J. Sweeney, MD, MPH, PhD
Providence Medical Association

Nitin S. Damle, MD
Washington County Medical Society

Cover: "Tombstone of Countess Olga Lvovna Shakhovskaya," photograph by Vlad Zayas, MD. The story behind this tombstone and others like is told by Dr. Zayas on page 267 of this journal.

Medicine & Health RHODE ISLAND

VOLUME 94 No. 9 September 2011

PUBLICATION OF THE RHODE ISLAND MEDICAL SOCIETY

COMMENTARIES

254 A Great Case!
Joseph H. Friedman, MD

255 Mortal Outcomes When Opportunity Knocks
Stanley M. Aronson, MD

CONTRIBUTIONS

Special Theme: JUDICIAL ENFORCEMENT
Guest Editor: Lawrence W. Vernaglia, JD, MPH

256 Judicial Enforcement – Introduction
Lawrence W. Vernaglia, JD, MPH

257 Making Sense of Physician Regulatory Risk in the Post-Health Reform Era
Lawrence W. Vernaglia, JD, MPH

261 Federal Prosecution of Health Care Fraud
Luis M. Matos

263 Why Do Physicians Get in Trouble? An Alaysis of Rhode Island Medical Board Reported Complaints and Resolutions
Bruce McIntyre, JD

268 Fraud in Health Care and Organized Crime
James F. Dube, JD

270 On Tombstone
Vlad Zayas, MD

COLUMNS

271 QUALITY CARE & PATIENT SAFETY FOR THE PRACTICING PHYSICIAN:
Assessment and Management of Pain in a Residential Medical Clinic
Katherine Fox, MD, Brian Hollenbeck, MD, Katherine Moore, MD, Helena Walsh, MD, and Mark Schleinitz, MD

274 THE CREATIVE CLINICIAN: Synovial Chondromatosis
N. Peter Libbey, MD, and Franklin Mirrer, MD

276 HEALTH BY NUMBERS: Multivitamin Use prior to Pregnancy in Rhode Island
Hyun (Hanna) Kim, PhD, Rachel Cain, BA, and Samara Viner-Brown, MS

279 PHYSICIAN'S LEXICON: An Epidemic of Words
Stanley M. Aronson, MD

279 Vital Statistics

280 September Heritage

Medicine and Health/Rhode Island (USPS 464-820), a monthly publication, is owned and published by the Rhode Island Medical Society, 235 Promenade St., Suite 500, Providence, RI 02908. Phone: (401) 331-3207. Single copies \$5.00, individual subscriptions \$50.00 per year, and \$100 per year for institutional subscriptions. Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society, unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Periodicals postage paid at Providence, Rhode Island. ISSN 1086-5462. POSTMASTER: Send address changes to *Medicine and Health/Rhode Island*, 235 Promenade St., Suite 500, Providence, RI 02908. Classified Information: Cheryl Turcotte/Rhode Island Medical Society, phone: (401) 331-3207, fax: (401) 751-8050, e-mail: cturcotte@rimed.org. Information on permissions and reprints available from jdttee@rimed.org.

Note: *Medicine & Health/Rhode Island* appears on www.rimed.org, under Publications.



Commentaries

A Great Case!



DOCTORS GET INTO TROUBLE WHEN THEY CONFUSE the patient and their disease. We do this often, without thinking about it, partly as a sort of shorthand, and partly out of a need to insulate ourselves. I am thinking of the people who the housestaff describe as, “this 50 year old drug addict,” “this unfortunate 37 year old schizophrenic” or “an elderly alcoholic.” I initially thought that we do this only when the patient has disorders that are at the lower end of the “moral” scale we often use in thinking of medical disorders, with rare somatic diseases at the top, mental illness at the lower section and drug abusers at the very bottom. But this turns out not to be true. We often hear about, “60 year old diabetics,” “25 year old leukemics,” “40 year old vasculopath,” in which diagnoses do not register on the moral scorecard, so I’ve been thinking about what it means when we speak of “a diabetic” rather than “a diabetic woman,” or “a leukemic,” rather than “a man with leukemia.” Why should we be insulating ourselves from these disorders but not when we speak of a person with AIDS, or coronary artery disease? When do we speak of a “dement” rather than a “demented person,” an “epileptic” rather than a person with epilepsy? I don’t know the answer and it troubles me. Labeling our patients by their disease certainly distances us from them but does it diminish them? I tend to think it does, but I’m not sure. It shortens a clinical presentation by only a single word.

One of the issues related to this is the “interesting” case and the “great” case, measures of enthusiasm, usually by house-officers and fellows, occasionally students or young attendings. “Come see this ‘great case.’”

During my residency, my mentor-in-chief, a deservedly famous neurologist remarked, after hearing a resident say, “I’ve got a great case to tell you about,” “When a resident tells me he has a great case, it’s never good news for the patient.” I can’t recall whether I, too, talked about “great

cases” or not before that observation, but I’ve tried to distinguish “interesting” cases from “great cases,” and, in all cases, distinguish the problem from the patient. We all learn early on that the nicer the patient, the worse the disorder.

An interesting case is just that, an unusual problem, an unusual collection of problems, a challenging diagnostic or treatment problem, something perhaps we’ve not heard of, or something we have heard of but never seen, or something we “know” that we know but the tests prove us wrong.

A “great” case is a challenging problem from which the patient gets better and the doctor looks like a genius. An interesting case is a rare enzyme-deficiency state, whereas a great case is an enzyme-deficiency state in which we can supply a remedy via a special diet or some other intervention.

My greatest cases involved solving a problem of paroxysmal spells of abnormal behavior that looked to all the world like intoxication in people who didn’t drink or use drugs, but who had had a myriad of tests repeated at a myriad of institutions, all of which were normal. The greatness of the case lay in the simplicity of the diagnostic tool, and the outcome. These patients had to be brought to the office during a spell and had to agree to have blood and urine tests, which proved they were, in fact, intoxicated, although they denied it. After detox programs they got their lives back.

An interesting case was a man who had been to the “world’s greatest hospital” in Boston where the expert failed to recognize a skin problem, most likely because he saw the patient during the winter and I saw him during the summer when he was wearing shorts and noticed a peculiar color change in the legs. I can guarantee that I would not have raised his trouser legs to look at his calves had he been wearing pants, and made the observation purely by chance. Now I raise the

trouser legs to look for this discoloration when I’m stumped, but only because I would have missed the diagnosis in the last case.

I missed a case of Wilson’s disease once. I thought the patient had a rather routine and unremarkable diagnosis of essential tremor, but several months later his second-opinion neurologist, a professional friend, contacted me to let me know about the Wilson’s diagnosis. Unfortunately I never received his note so I don’t know if he actually thought of that diagnosis, or simply runs lots of tests on all his tremor patients (something I pride myself on not doing). So, I don’t know if he was brilliant, I was stupid or he just orders too many tests. Certainly this was a “great” find for the patient, saving him further grief from liver or brain deterioration, and, therefore a “great” case.

We need to be careful how we convey our enthusiasm to our patient. We need them to understand that we are interested in them even more than in their disease, that we serve them and do not simply get our satisfaction from solving difficult problems to burnish our reputations.

— JOSEPH H. FRIEDMAN, MD

Disclosure of Financial Interests

Lectures: Teva, Ingelheim Boehringer; General Electric

Consulting: United Biosource; Buba-loo, Halsted, Reitman LLC; EMD Serono; Genzyme; Teva; Acadia; Addex Pharm; Schwarz Pharma

Research: MJFox; NIH; Cephalon; EMD Serono; Teva; Acadia

Royalties: Demos Press

CORRESPONDENCE

e-mail: joseph_friedman@brown.edu

Mortal Outcomes When Opportunity Knocks

WORDS ARE TENACIOUS THINGS BUT NOT IN THEIR MEANING OR INTERPRETATION.

Consider the noun, opportunity, derived from the Latin meaning 'toward the harbor'. It has been in the active English vocabulary for a long time and is currently defined as an occasion or a time that is either favorable or appropriate, even seasonable. It can be transformed into a useful adjective, opportune, as descriptive of something which, again, is suitable.

Opportune, as an adjective, conveys the sense of appropriateness or suitability; and tacitly, it describes occasions that are propitious, felicitous as well as timely. Thus, to hold a wedding would be regarded, properly, as opportune.

A happy opportunity describes a joyous birthday party to which you had been formally invited; opportunism, on the other hand, describes the same party, but your admittance is more likely through gate-crashing. And opportunistic may be additionally defined as a tendency to adapt one's behavior to circumstance rather than to a moral principle.

And opportunism, derived from the same ancient root, now brings a special nuance to the word, suggesting that the achievement of a favorable status is brought about, not by an intersection of favorable pathways – a benign happenstance – but rather through conscious connivance.

And so now we confront the adjective, opportunistic, a word that has a profound meaning in the world of contemporary epidemiology and medicine. Until the advent of reason-based medicine in the middle decades of the 20th Century, the desperately ill rarely survived in the absence of antibiotics and access to the range of interventions collectively called intensive care. These newer, life-saving interventions include chemotherapies to suppress cancers, body irradiation, heroic surgical procedures and the use of steroids thus collectively creating a new category of patients still living but now intensely fragile and increasingly vulnerable to otherwise non-invasive germs, by virtue of their suppressed and therefore inadequate immune systems.

To understand this sea-change in the nature of medical practice, we begin with a biological reality: Except for vulnerable children living in pathogen-free bubbles we all live in a world contaminated by an immense variety of microscopic organisms including viruses, bacteria and fungi, all in measureless numbers.

These microscopic organisms have prospered in the extremes of global existence, from the ice-masses of Antarctica to the volcanic eruptions in the depths of the Pacific Ocean and all intervening terrains. And they inhabit everything we touch or eat. But under normal circumstances they are not endowed with invasive properties—and so there is a happy coexistence between the vast majority of micro-organisms and humanity.

Medicine's great achievements in the last half-century, however, has now created a paradox: Countless humans are now kept alive by these achievements; but simultaneously, they are now living with continuing impairments particularly in their capacity to ward off the depredations of surrounding germs; and thus these patients become newly vulnerable to organisms that would otherwise be harmless. And so, in recent decades, an entirely new category of disease has arisen, illnesses called

opportunistic infection, representing those organism-caused ailments the consequence of relatively innocent micro-organisms exploiting humans with deficient immunological defenses.

In the past, chronic diseases have pursued their relentless courses uninterrupted by medicines or other interventions. Seneca, the great Roman orator who lived in an era when medicine exerted little influence upon the trajectory of human disease, made the following observation: "If prolonged, it (the illness) cannot be severe, and if severe it cannot be prolonged." Accordingly and until the 20th Century, chronicity (the prolongation of disease) was rare; and if present, confined to such non-mortal afflictions as arthritis.

Medicine now has the audacity to interfere with the natural flow of pathologic events, and the results are twofold: Vast numbers of people are now living longer; but many of them are also companion to opportunistic infections, something that the Roman physicians of Seneca's era never encountered. In the competitive microbiological world, there are no free lunches.

Opportunity is a wondrous word. It denotes a world of great possibilities. America, for example, is called the fabled land of opportunity and the word has come to define those who take advantage of fleeting opportunities, whether they be courageous pioneers, clever inventors or, alternatively, assertive entrepreneurs, used-car salesmen, even pirates. Ultimately, I suppose, nothing is truly safe. Without locks and other safeguards, certainly Fort Knox is vulnerable. And in our increasingly complex Darwinian world, even germs may now display opportunism.

– STANLEY M. ARONSON, MD

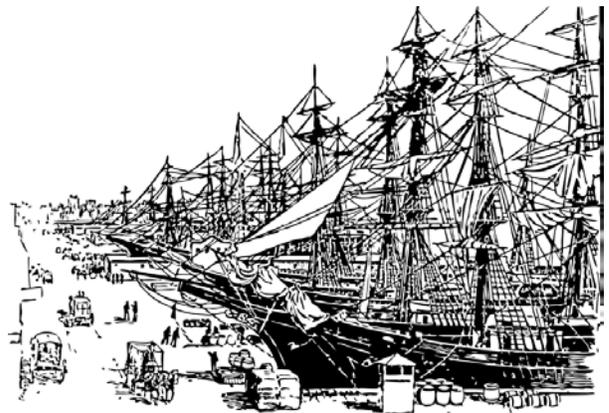
Stanley M. Aronson, MD is dean of medicine emeritus, Brown University.

Disclosure of Financial Interests

The author and their spouse/significant other have no financial interests to disclose.

CORRESPONDENCE

e-mail: SMAMD@cox.net



Judicial Enforcement – Introduction

Lawrence W. Vernaglia, JD, MPH

IT IS REGRETTABLE, BUT TRUE, THAT COMPLIANCE, ENFORCEMENT AND POTENTIAL LIABILITY are part of the fabric of the health care industry today. When the cost of care was a much smaller fraction of State and Federal budgets, health care services could be “under the radar.” Quality and professionalism could be policed by the “guild.” Thus, in the past the Medical Society, hospital medical staffs, and (occasionally) law enforcement would intervene in egregious cases, generally involving malpractice. That era has passed. The economics of health care, and the attention of the public and government, has now made health care enforcement a key focus in the national health care delivery system. Physicians are not spared that focus. Malpractice insurance generally protects physicians from all but the psychic and reputational damages of negligence cases. But insurance does not regularly protect against the new regime of health care enforcement under fraud & abuse, overpayments, and other regulatory risks.

This issue contains several key perspectives on the liability and regulatory risks experienced by physicians and other health care providers in this new era. We have solicited contributions from three of the key health care enforcement professionals in the State—from perspectives of the Board of Medicine, the U.S. Department of Justice, and the Rhode Island Attorney General’s Medicaid Fraud and Patient Abuse Unit. These articles begin with an introduction from the perspective of a health care providers’

lawyer trying to put these risks into a broader context. That context is both informative and comforting: most physicians will never encounter the enforcement apparatus of government—if they play by the rules. But the rules are complex and changing. And the stakes continue to increase, not just in terms of the health and safety of patients, but also the fiscal implications of health care.

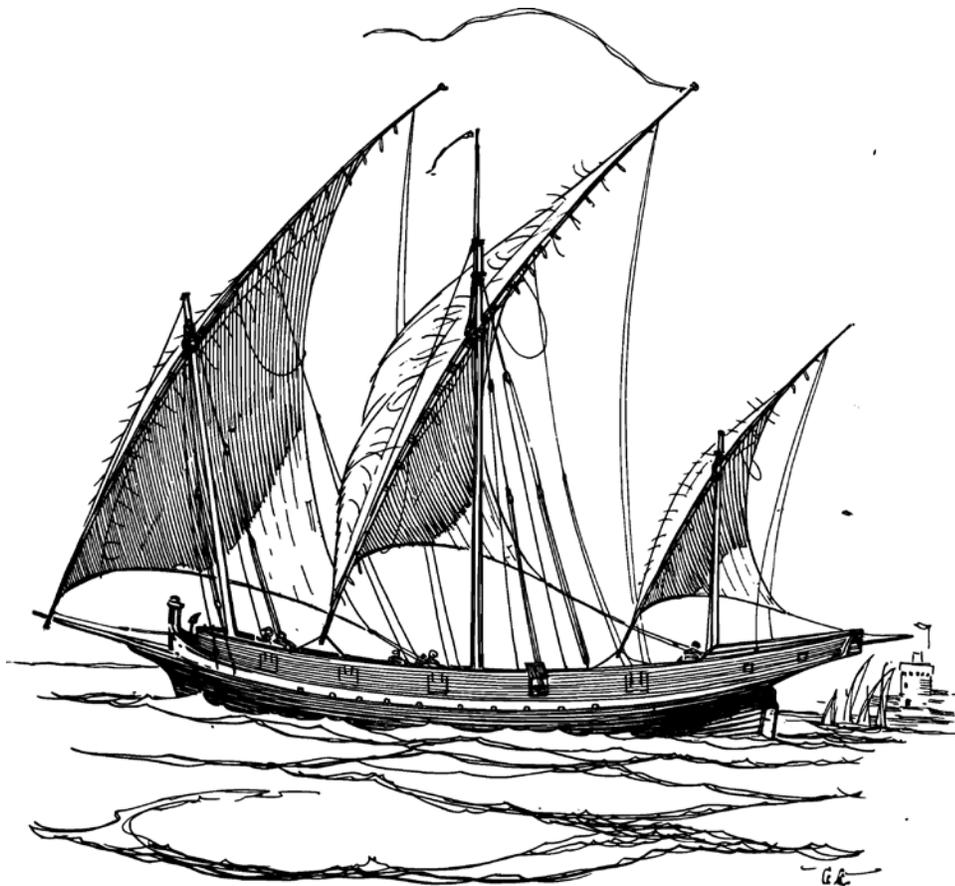
Lawrence W. Vernaglia, JD, MPH, is an attorney specializing in health care with Foley & Lardner, LLP where he is a partner and the Chair of the Firm’s national Health Care Industry Team. He is a member of the Editorial Board of Medicine & Health Rhode Island.

Disclosure of Financial Interest

The author and/or their significant other have no financial interests to disclose.

CORRESPONDENCE

Lawrence W. Vernaglia, JD, MPH
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02109
Phone: (617) 342-4079
e-mail: lvernaglia@foley.com



Making Sense of Physician Regulatory Risk in the Post-Health Reform Era

Lawrence W. Vernaglia, JD, MPH

A VARIETY OF FACTORS IS COALESCING ON the state and national levels that have increased the risks to physicians and other health care providers relating to fraud, waste and abuse. Though most enforcement resources are being directed, rightly, at true “bad guys” (providers intentionally defrauding the governmental and private health care payors), the complexity of providing health care in the post-Health Reform era means that even the “good guys” need to apply a level of care to their business dealings that was not required in prior generations. This essay provides a few data points from the most recent governmental initiatives that support this thesis, and highlights some of the evolving trends and areas of risk for physicians in particular.

The Health Reform law, also known as the **Patient Protection and Affordable Care Act of 2010** [Pub. L. No. 111-148, 124 Stat. 119 (2010)] (PPACA) went into effect on March 23, 2010, and lawsuits were filed in a number of jurisdictions to repeal the Act almost immediately.¹ While the lawsuits focus on the constitutionality of one key portion of PPACA (Section 1501 (or the “Minimum Essential Coverage Provision”)) the broader practical objection has been that Health Reform on a national level will be extremely expensive to deliver. While there are likely too many variables in play for anyone to provide an accurate figure, news sources reported that the estimated cost would be one trillion dollars. While reasonable people may differ, even the staunchest advocates of reform, who expect to see ultimate savings from changes to the insurance and health care delivery systems, acknowledge that there are significant costs to be incurred in achieving the goals of Health Reform.

Where will these funds come from? Though there is little appetite in a still-down economy to raise taxes, there is always room for more fraud busting. The President, speaking to Congress in support of PPACA in the Fall of 2009, stated: “we’ve estimated that most of this plan

can be paid for by finding savings within the existing health care system—a system that is currently full of waste and abuse.”² Shortly before passage of PPACA, President Obama speaking at a rally in St. Charles, Missouri further underscored the Administration’s views of the role of fraud and abuse in the health care system, opining “[i]f we created a Department of Improper Payments, it would be one of the largest agencies in our government.”³ Thus, the Administration is signaling that combating fraud, waste and abuse will be one of the strategies for paying for health care reform. PPACA, itself, included new resources, such as an additional \$250 million over six years to fund fraud and abuse enforcement, with another \$95 million for **Federal Fiscal Year (FY) 2011** alone.

Governmental fraud enforcement efforts are continuing at an impressive pace. One of the most visible developments has been the Federal HEAT initiative—the **Health Care Fraud Prevention & Enforcement Action Team (HEAT)**, a joint initiative announced in May 2009 between the **Department of Justice (DOJ)** and the **Department of Health and Human Services (HHS)** to collaborate on Medicare and Medicaid fraud prevention and prosecutions. Such inter-agency collaboration has been taking place for many years, but the results of late are impressive—with hundreds of arrests in South Florida, Detroit and other targeted areas. On January 11, 2011, the DOJ and HHS issued their annual report⁴ for the **Health Care Fraud and Abuse Control (HCFAC)** Program, reporting the following highlights of activities during FY 2010:

- \$2.5 billion in health care fraud judgments and settlements;
- \$2.86 billion received by the Medicare Trust Fund;
- \$683.2 million in Federal Medicaid money recovered to the Federal government;

- 1,116 new criminal health care fraud investigations commenced against 2,095 potential defendants;
- 1,787 health care fraud criminal investigations pending against some 2,977 potential defendants (showing that the majority of active cases were filed in 2010)
- 488 cases involving 931 defendants had new criminal charges filed;
- 726 defendants were convicted for health care fraud-related crimes;
- 942 new civil health care fraud investigations with 1,290 civil health care fraud matters pending; and
- 3,340 individuals and entities were excluded from participating in Medicare, Medicaid and other Federal health care programs by the **Office of the Inspector General (OIG)**.

These figures represent enforcement efforts against all types of providers. The OIG and other enforcement entities continue to pursue their investigations and audits of physicians and others. The OIG’s 2011 Work Plan presents to the industry some of the top issues the OIG will study in the coming year. For physicians, the Work Plan includes risks associated with (among others):

Place-of-service errors;

- Coding and payments for **evaluation and management (E&M)** services;
- E&M payments during the “global surgical” period;
- Payments for Part B imaging services and other diagnostic tests;
- Sleep studies;
- Compliance with Medicare’s “Assignment” rules; and
- Payments for services ordered by “excluded” providers.

What types of initiatives new should physicians expect? There are several ranging from delays and changes in enrollment in the Federal health care programs, new fraud investigators, restrictions on the ability to profit from ancillaries and tighter enforcement statutes to enhanced personal liability. The following paragraphs summarize a number of these developments.

ENROLLMENT RESTRICTIONS

Much of the Government attention has been correctly focused on keeping criminal elements out of the Medicare and Medicaid programs. A variety of provisions in PPACA are designed to help HHS combat fraud, waste, or abuse through the enrollment or revalidation processes. The law contains a number of new tools that are likely to be targeted at certain “high risk” categories of providers and suppliers in particular home health and durable medical equipment. Abuse in these areas has been a key target of the Federal HEAT initiative, discussed above. Because abuse in DME and home health sectors has been such a focus of attention, PPACA now requires that physicians must have face-to-face encounter with a patient prior to certification for home health services or DME, and only Medicare-enrolled physicians may order DME or certify home health services.

Changes in the area of enrollment and screening included different levels of screening will vary among categories of providers and suppliers, such as license checks, fingerprinting, criminal background checks, multi-state database inquiries, random or unannounced site visits, or other appropriate screening technologies. Certain types of providers and suppliers may be subject to a temporary “provisional period” (30 days to one year). During this “provisional period” the provider or supplier may be subject to enhanced oversight, prepayment review, prepayment caps. Enrollment applications will now require disclosures of affiliation with providers that have uncollected debt, or who have been suspended or excluded from participation. The Act also allows for enhanced civil money penalties for providers making false statements in enrollment the process. What this all means for physicians likely is more delays, hassles and claims

interruption when bringing on new physicians or when changing practice settings. On the whole, however, most physicians will welcome any efforts to keep the unscrupulous and corrupt providers out of the market.

**Much of the
Government
attention has been
correctly focused
on keeping criminal
elements out of
the Medicare and
Medicaid programs.**

MANDATORY COMPLIANCE PROGRAMS

Compliance programs have been recognized as valuable internal tools to prevent overbilling or other regulatory violations. These programs, though lauded by prosecutors and providers alike, have historically been voluntary. The OIG published a Compliance Program Guidance document for Individual and Small Group Physician Practices on October 5, 2000⁵ with the OIG’s recommendations for how physicians should set up a voluntary compliance program in their offices. After PPACA, these voluntary programs will be mandatory. All providers and suppliers as a condition of enrollment in Medicare, Medicaid, and/or CHIP must implement compliance programs subject to a variety of requirements the **Centers for Medicare and Medicaid Services (CMS)** will impose by regulation. As of this printing, CMS has invited comments but not outlined the mandatory terms of such programs.⁶ It is unknown whether smaller physician groups will be asked to undertake significant efforts in this area. Nevertheless, the advantages to physician groups of establishing a compliance program now are many, including an enhanced ability to detect and prevent violations—not to mention the ability to earn favor in the eyes of a prosecutor or regulator if an investigation is undertaken against a physician group that has an ef-

fective compliance program. Medical staff education around office-based compliance programs has been ongoing in Rhode Island and likely will increase as physicians recognize the need to implement such programs in their practices.

ENHANCEMENTS TO THE FALSE CLAIMS ACT AND THE ANTI-KICKBACK STATUTE

PPACA (and prior statutes) introduced changes to several of the key enforcement—including the most important law, the **False Claims Act (FCA)**. The FCA is valuable to the government because it includes the opportunity for treble damages plus \$11,000 per claim penalties. In addition, the FCA permits private “whistle-blower” or *qui tam* plaintiffs to bring cases in the name of the government and recover a share of the reward. The changes to the FCA were designed to (1) make it easier to prove a violation against a provider and (2) encourage *qui tam* law suits. PPACA weakens the so-called “public disclosure bar” by restricting scope of information considered “publicly disclosed” and, therefore, unable to support a *qui tam* case and expanding definition of “original source,” thus permitting many additional private plaintiffs to bring cases under the FCA.

Physicians have long known that the Federal and Rhode Island Anti-Kickback Statutes prohibited knowingly paying or soliciting any remuneration with the intent that it cause the physician or other provider to refer a patient for a Medicare, Medicaid or other federal or state health care program service. *Medicine & Health/RI* has included articles over the years designed to help physicians navigate the law and the many exceptions and regulatory “safe harbors” that define illegal conduct from acceptable business arrangements. Concerned that case law had been too lenient on providers, Congress in PPACA amended the law to state that a person “need not have actual knowledge of this section or specific intent to commit a violation of this section.” This was intended to eliminate the “*Hanlester* defense” named after one of the first major Anti-Kickback cases, *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995). Additionally, PPACA added new language to assure that claims billed for items or services resulting from a violation of the Anti-Kickback Statute constitute

false claims under the FCA. Physicians should remain vigilant about financial dealings with other health care providers as well as drug and device companies to be sure that they do not get ensnared in an Anti-kickback prosecution.

STARK LAW CHANGES

There were several changes to the Physician Self-Referral or “Stark” law that will be important to physicians. One of the most immediate Stark changes for physicians is a new documentation requirement for the use of the “In-Office Ancillary Services” exception. This exception allows physicians to provide needed ancillary services in their office and refer patients for those services. Under the new requirement, as interpreted by CMS,⁷ physician, ordering certain MRI, CT, and PET scans must inform patients in writing that they may obtain service from an alternate supplier and include a list of suppliers furnishing same service in area around the physician’s office. These new forms have been required as of January 1, 2011.

CMS now has the authority to settle and compromise Stark Law violations. Historically, there have been few avenues to bring voluntary disclosures of Stark violations to the attention of the government without having to repay 100% of the Medicare referrals associated with the financial relationship. This draconian result was particularly unfair as the Stark Law (unlike the Anti-Kickback Statute) discussed above, has no “intent” standard, thus making inadvertent contracting errors as serious as intentional violations. Until 2009, physicians, hospitals and others could bring Stark violations to the attention of the OIG through its self-disclosure protocol, but the OIG recently announced that it would no longer accept “Stark-only” disclosures (*i.e.*, violations without “colorable” Anti-Kickback violations). Under PPACA, providers and suppliers may enter into a **Self-Referral Disclosure Protocol (SRDP)** with CMS for Stark violations and negotiate a settlement below the 100% severe penalty. There have been few settlements under the SRDP as of this printing, so the metrics CMS is using are not yet well known. However, the agency is considering:

- The nature and extent of “illegal or improper practice”
- Timeliness of disclosure;
- Cooperation in providing additional information;
- Litigation risk; and
- “Other factors.”

Finally, PPACA ends the debate on whether to permit the expansion of physician-owned hospitals. While not prevalent in New England and Rhode Island, other regions of the country experienced great competition coming from physician-owned hospitals against the community hospitals. After the change in the law, a moratorium on new physician-owned hospitals applies to any hospitals without a Medicare provider agreement as of Dec. 31, 2010. Existing physician-owned hospitals can no longer increase capacity or the percentage of physician ownership or investment after March 23, 2010. There are limited exceptions available for hospitals that treat the highest percentage of Medicaid patients in the county, or that have a high Medicaid percentage and are located in high-growth, underserved areas.

MANDATORY REFUND AND REPORTING OF OVERPAYMENTS

Overpayments can be caused by any number of factors—and sometimes it is highly questionable whether a specific payment is an overpayment at all. This is due to the complexity of the billing rules, uneven guidance from payors, and significant “gray areas” in interpretation of these rules in the context of medical records, diagnoses, and clinical practice. In the past, many health care attorneys saw no express duty to refund innocent overpayments discovered after payment. The DOJ and CMS disagreed, and alleged that “wrongful retention” of an overpayment was illegal. Two significant legislative changes, including both PPACA in 2010 and the 2009 **Fraud Enforcement and Recovery Act (FERA)** amendments, materially improved the government’s hand in this area. These laws expressly reference improper retention of overpayments as the basis for a FCA prosecution. PPACA heightened this risk by imposing an express duty to refund and report Medicare and Medicaid overpayments by *the later* of 60 days after the overpayment is “identified” or the

date cost report is due (for cost reporting providers). And the failure to report and return the overpayment exposes the provider to liability under the FCA.

This change in the law requires immediate action by physicians and other providers. In particular, office staff need to be trained to know when an overpayment has been “identified” and to bring this promptly to the attention of someone with the authority to evaluate whether the overpayment is real and take the required steps. There are also some important undefined elements of the law, including when an overpayment is “identified,” what level of certainty or confidence is required, and the actual processes required.

PHYSICIAN PAYMENT “SUNSHINE”

Discussed for many years by Senator Charles Grassley and debated in a number of states (including Rhode Island), physician financial relationships with drug and device companies is now regulated on both the state and Federal levels. These so-called “sunshine” laws are motivated by the concern that gifts and payments by manufacturers to physicians may lead to conflicts of interest and improperly influence physicians in their drug or device prescribing decisions. These laws do not prohibit physician involvement in research and education with industry, but they impose various new compliance requirements on these relationships, and also require public disclosure of arrangements that previously were treated as confidential. A number of states, including Massachusetts, Maine and Vermont, passed local laws. Some states, like Massachusetts and Vermont ban “gifts” and require disclosure of financial relationships on state website.

PPACA now federalizes this area, requiring “transparency reports” of payments by “applicable manufacturers” of a drug, device, biological, or medical supply. These reports will begin on March 31, 2013 and will disclose to HHS payments or other transfers of value to a physician or “teaching hospital.” Reports will contain the physician and teaching hospital names and business addresses, dates and amounts of payments, and description of the nature of payment. Disclosure of some confidential information relating to clinical trials will be permitted prior to FDA approval/clearance or four years. There

are minimal exemptions for the reports. Payments of less than ten dollars each, up to \$100 aggregate, educational materials, evaluation units of devices, discounts and rebates, expert witness fees and a few other arrangements do not require disclosure.

EXPANSION OF THE “RAC” PROGRAM AND OTHER NEW AUDITORS

Physicians doing Medicare work in Massachusetts, New York, California and Florida are familiar with the **Recovery Audit Contractor (RAC)** program. This program engages contingency Fee “bounty hunter” contractors to find overpayments in Medicare parts A and B. This Medicare RAC program commenced as a demonstration in three states, but expanded nationally in 2009. The results of the contingency fee model have been so successful (a good “return on investment” according to CMS) that Congress has now further expanded RAC to Medicaid as well as Medicare parts C and D. Thus, Rhode Island physicians must be prepared for requests for charts and demands for overpayment refunds from Medicare and Medicaid. Failure to respond to these contractors will result in automatic overpayment demands.

The RACs join an alphabet soup of other auditors physicians may encounter, including **Zone Program Integrity Contractors (ZPIC)**, encompassing what was handled by **Program Safety Contractors (PSC)**, and **Medicaid Integrity Contractors (MIC)**. These auditors are an overlay on the existing apparatus of enforcement and investigation by the **OIG, Medicaid Fraud Control Units (MFCU)**, **DOJ**, and **State Attorneys General**. For physicians, this requires a greater familiarity with who is out there, what they are looking for, and what rights you have when they are asking questions.

INDIVIDUAL LIABILITY

Most of the attention in health care enforcement cases has been on recovering overpayments and imposing other financial penalties. Though personal criminal or civil liability has always been a risk, it has not been a central element of the fraud and abuse enforcement regime. This may be changing, based on activities like the **HEAT** initiative, discussed above, and increasingly strong rhetoric from the **DOJ**.

REFERENCES

1. See, e.g., *Virginia ex. rel. Cuccinelli v. Sebelius*, 702 F.Supp2d 598 (2010).
2. H9390 Congressional Record—House (September 9, 2009)
3. Full text of speech (3/10/2010) downloaded from <http://www.mainjustice.com/2010/03/10/obama-speech-on-health-care-waste-and-fraud/> (February 21, 2011).
4. Downloaded from <http://www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf> (February 21, 2011)
5. 65 Fed. Reg. 59434.
6. 75 Fed. Reg. 58204 (September 23, 2010)
7. 75 Fed Reg. 73443-73447 (Nov. 29, 2010)

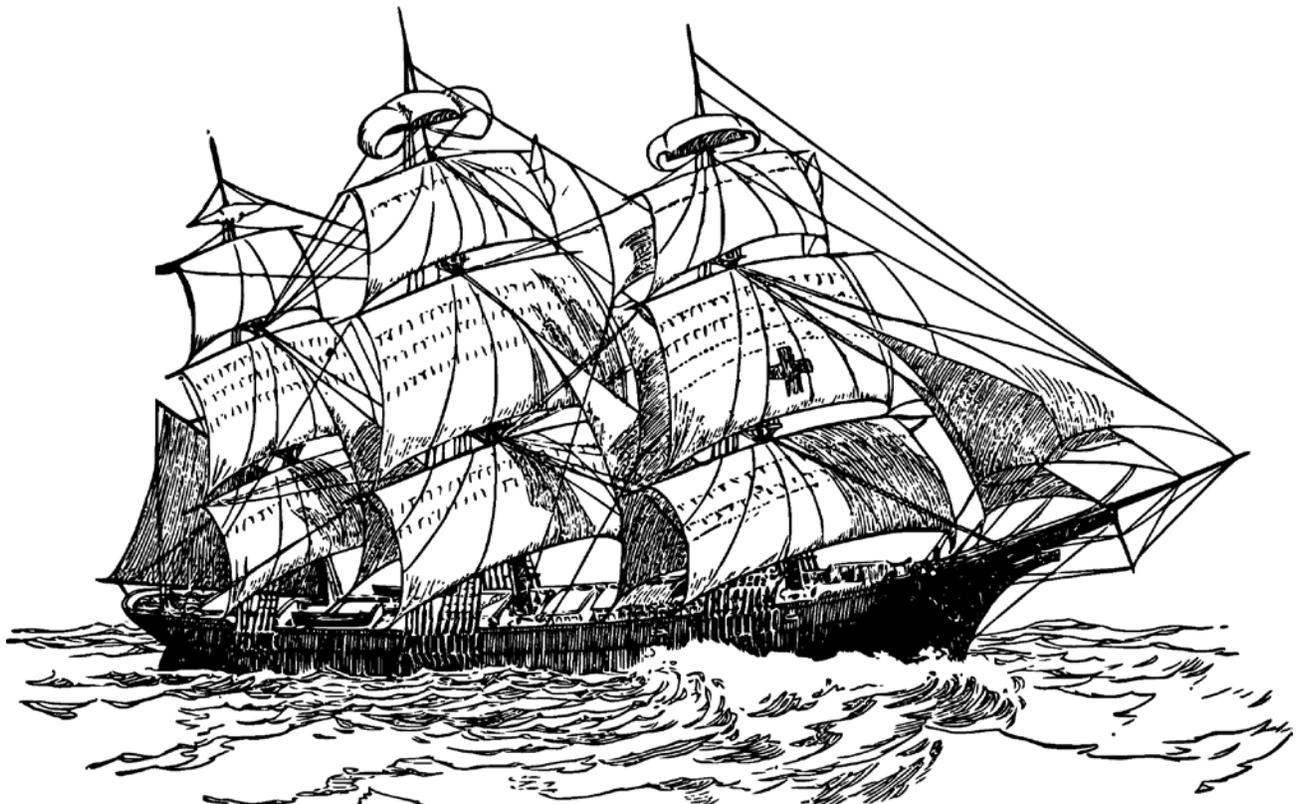
Lawrence W. Vernaglia, JD, MPH, is an attorney specializing in health care with Foley & Lardner, LLP where he is a partner and the Chair of the Firm's national Health Care Industry Team. He is a member of the Editorial Board of Medicine & Health Rhode Island.

Disclosure of Financial Interest

The author and/or their significant other have no financial interests to disclose.

CORRESPONDENCE

Lawrence W. Vernaglia, JD, MPH
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02109
Phone: (617) 342-4079
e-mail: lvernaglia@foley.com



Federal Prosecution of Health Care Fraud

Luis M. Matos, JD

EVERY YEAR, HUNDREDS OF BILLIONS OF TAX dollars are spent to provide health care to our seniors, children, the poor and the disabled. Programs that are intended to provide benefits to beneficiaries and fair reimbursement to providers are also prime, and, at times, easy targets for the unscrupulous who seek to enrich themselves. Prosecuting health care fraud has been a decades-long emphasis of the United States Department of Justice and is presently one of its top priorities.

In 1997, Congress established the Health Care Fraud and Abuse Control program under the joint direction of the Attorney General and the **Department of Health and Human Services, Office of Inspector General (HHS-OIG)**. Their joint mission is to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Since the inception of the program, the work of the two departments and their law enforcement partners has returned more than \$15 billion to the federal government, including \$13.1 billion which was returned to the Medicare Trust Fund. Federal prosecutors have also obtained more than 5,600 criminal convictions during that time period.¹ In fiscal year 2010 alone, the United States recovered \$2.5 billion in health care fraud judgments and settlements.

The nature and size of the cases run the gamut. For example, last year Pfizer Inc. and its subsidiary, Pharmacia & Upjohn Company, agreed to pay \$2.3 billion to resolve criminal and civil allegations arising from the promotion of certain pharmaceutical products. In Texas, a hospital group agreed to pay the United States \$27.5 million to settle claims that it paid illegal compensation to doctors in order to induce the doctors to refer patients to the group. In August of last year, a doctor in Michigan was convicted of health care fraud for receiving kickbacks and falsifying documents relating to the provision of home health care services that were never provided. He

was sentenced to 168 months in prison and ordered to pay \$9.5 million in restitution for his part in the five-year long scheme. In December, the parent company of two New Jersey hospitals paid \$7.9 million to resolve allegations that the hospitals wrongfully obtained excessive outlier payments. In March of 2010, a cancer center in Florida agreed to pay \$12 million to resolve allegations that the center and one of its physicians improperly inflated claims by billing for services not rendered, services not supervised, duplicative and unnecessary services, and upcoded services. Finally, in Chicago, a medical center agreed to pay \$1.5 million to resolve allegations that it had submitted false claims to Medicare and Medicaid by entering into an improper leasing arrangement for office space with certain physicians in violation of the Stark Law, which prohibits a hospital from profiting from patient referrals made by a physician with whom the hospital has an improper financial arrangement.

**The goal of the
task force is
simple—to address
fraud and abuse
in a fair and
comprehensive way.**

In Rhode Island, Dr. Wallace Gonçalves is presently serving a ten year prison sentence resulting from his convictions for diluting and adulterating vaccines, submitting false statements to the government relating to immigration medical exams that he falsely claimed he had performed, selling drug samples to Cameron's Pawtuxet Pharmacy and conspiring to commit health care fraud in relation to the drug samples which were dispensed by Cameron's Pharmacy.

He was also ordered to pay \$1.1 million in fines and restitution. The owner of Cameron's Pharmacy was sentenced to 37 months in prison for illegally diverting free drug samples for sale at the pharmacy and also forfeited \$431,410.62 to the United States. Another doctor is presently a fugitive from charges that he committed approximately \$2.9 million in health care fraud by upcoding billings for infusion drugs, billing for services not provided, and falsely prescribing drugs without medical justification. Although he is a fugitive, the government seized more than \$2 million of his assets, including a house owned by the doctor and money from his bank accounts, in order to offset the false billings.

Such results are achieved through the cooperative work of the region's law enforcement personnel who work jointly in order to maximize the legal tools available to them. That work is generally coordinated through a health care fraud task force that meets regularly to discuss cases, share leads, and address on-going issues. It is comprised of members of various agencies, including the US Attorney's Office, the RI Attorney General's Medicaid Fraud Control Unit, the HHS-OIG, the Federal Bureau of Investigation, the US Food and Drug Administration, the Department of Labor, US Drug Enforcement Agency, the Department of Veteran's Affairs, the US Postal Service, the Internal Revenue Service and the RI State Police. In addition, representatives of private insurance companies regularly attend task force meetings so that law enforcement may maintain a continuing dialogue with them and address issues of fraud and abuse affecting private insurers. The task force also regularly exchanges information with the RI Department of Health on matters of mutual interest.

The goal of the task force is simple—to address fraud and abuse in a fair and comprehensive way. This may mean that, if the evidence is sufficient, a matter will be pursued criminally. That is, if the evidence shows that someone intentionally and knowingly defrauded a health care benefit program, such as Medicare or a

The writer is an Assistant United States Attorney for the District of Rhode Island. The views expressed herein do not represent the views of the United States Department of Justice.

private insurance company, then the matter may be presented to a grand jury for indictment and subsequent prosecution. In the criminal context, if a defendant is convicted, he may not only be facing a term of incarceration but the government will also seek restitution, since, after all, the purpose of these efforts is to protect tax payer funds, and may seek forfeiture of the defendant's assets if those assets constitute proceeds of the scheme.

However, criminal prosecution may not be the only option. Many health care fraud cases, as reflected in the aforementioned case studies, are pursued in the civil arena, including cases pursued under the **False Claims Act (FCA)**. The FCA allows the government to sue a provider for "knowingly" submitting false claims to the government. In order to prove that a provider "knowingly" submitted false claims, the government must prove actual knowledge or a deliberate or reckless disregard for the truth, or falsity, of the claims. Hence, it is not a defense that a provider didn't have actual knowledge as long as the evidence shows that he or she acted in a manner that would inevitably lead to the submission of false claims. Hence, it is not enough for one to stick his head in the sand in order to avoid civil liability. In addition, the government need not prove the matter "beyond reasonable doubt," as in a criminal case, but must only establish its case by a preponderance of the evidence, which is a lower standard. The penalties in the civil arena are strong. The provider may be liable for up to three times the amount of the false bills submitted to Medicare or Medicaid and may also

be penalized between \$5,500 to \$11,000 for each, individual, false claim.²

Finally, the Department of Health and Human Services may also impose administrative penalties. For instance, if a provider is convicted of a health care offense, he or she may be subject to mandatory exclusion from the Medicare program. Other conduct, such as that captured by the False Claims Act, may be the subject of a permissive exclusion. Or, HHS may impose civil monetary penalties against providers who submit false claims, participate in illegal kick-back schemes, fail to appropriately treat or refer patients who present at hospital emergency rooms, or engage in other activities prescribe by statute. In addition, HHS also conducts numerous audits and evaluations in order to determine whether improper bills have been submitted to Medicare or Medicaid. Such audits may lead to recoupment actions by HHS or, if the conduct is egregious, referral to investigative agencies. Interference with such audits, including the falsification of documents, may also lead to enforcement actions by the United States.

As can be seen, the Department of Justice and its law enforcement partners have not only embarked on a comprehensive approach to combating health care fraud but they also have many tools at their disposal. The purpose of these efforts is not to pursue providers who make honest mistakes. If a provider is receiving money for services that are provided and are medically necessary, law enforcement should not be interested. Indeed, the system has built in safeguards designed to address the honest

mistakes, either through the audit process or the many educational offerings provided by the Centers for Medicare and Medicaid Services and the intermediaries who process the claims for Medicare and Medicaid.

However, it is also not enough for a provider to claim ignorance of the rules in order to avoid responsibility. It is not enough for a provider to claim that he left everything up to his biller or billing agency, if his conduct suggests that he knew of or created the circumstance for the false billing—such as ordering or providing services that were not medically necessary, creating records to establish that services were provided at a level higher than actually rendered, or which were based on improper financial relationships with other providers. In those cases, law enforcement will seek to address the wrongdoing and return the ill gotten funds to the public fisc.

NOTES

1. Data and national case studies contained herein were obtained from "The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," January 2011.
2. False Claims Act cases may be initiated by the United States, or they may be filed as "Qui Tam" lawsuits. A Qui Tam is a lawsuit that is filed by a citizen, referred to as a "relator," who possesses knowledge of wrongdoing. When a Qui Tam lawsuit is initiated, the United States has the option of intervening and pursuing the lawsuit or declining to intervene. If the United States declines to intervene, the relator may pursue the lawsuit nonetheless. In either event, the relator may receive a share of the damages, typically between 15 and 25 percent, if the lawsuit is successful. The False Claims Act also contains provisions prohibiting retaliation against the relator by the defendant in the lawsuit.

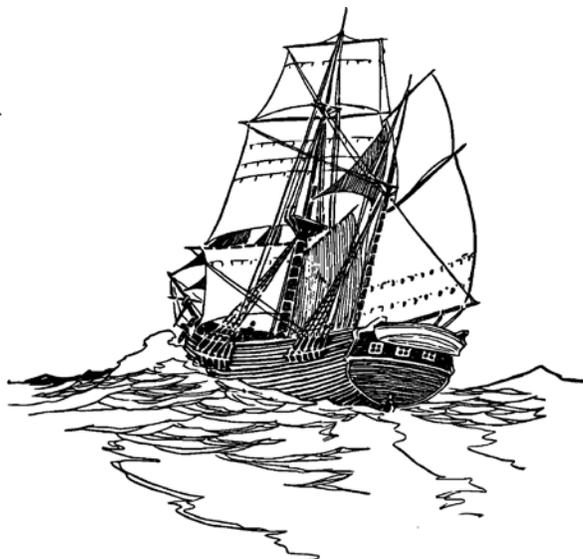
Luis M. Matos, JD is an Assistant United States Attorney for the District of Rhode Island.

Disclosure of Financial Interest

The author and/or their significant other have no financial interests to disclose.

CORRESPONDENCE

Luis M. Matos, JD
US Attorney's Office
50 Kennedy Plaza
Providence, RI 02903
phone: (401) 709-5000 ext. 46
e-mail: luis.matos@usdoj.gov



Why Do Physicians Get in Trouble?

An Analysis of Rhode Island Medical Board Reported Complaints and Resolutions

Bruce McIntyre, JD

INTRODUCTION

State Medical Licensing Boards seek to ensure that physicians have the appropriate tools to provide high quality, patient-centered care in a safe environment. With this goal in mind, State Medical Boards strive to enforce regulations in clinical practice, improve the administrative process and integrate information to improve the efficiency and quality of patient care. This issue raises the issue of, "Why do physician's get in trouble?" The answer is not a simple one because each complaint reviewed by the Board of Medical Licensure and Discipline is unique. Physicians must be aware of the jurisdictional regulations of the Board, understand the origination and jurisdiction of the Board, the complaint process, the data representing "misconduct," and their resolutions.

ORIGINATION AND NATIONAL REGULATION OF MEDICAL BOARDS

The authority to regulate the practice of medicine is established for the states in the 10th Amendment of the US Constitution. Since each state is responsible for the regulation of its own medical practitioners, each state established has a its own unique set of laws and standards. Interstate diversity continued until the states recognized the need to establish a national organization dedicated to unifying the various standards for professional licensing and conduct. This led to the creation of the **Federation of State Medical Boards (FSMB)** in 1912 to serve as a national resource for state medical boards' mission to protect the public. The FSMB eventually began to revolutionize the practice of medicine in the United States, by prompting the creation of the **Medical Practice Act (MPA)** in 1956. The MPA is a set of guidelines that broadly defines the practice of medicine and delegates the authority to enforce the law to each state medical board. All states have adopted the MPA guidelines to create or amend

existing laws for preservation of public interest, and to maintain high professional standards in the practice of medicine. This incorporation of the MPA by the various states and regulatory bodies has strengthened cooperation among state medical boards and facilitated collaborative efforts with other entities. The FSMB continues to represent all 70 medical boards of the United States and its territories, including the 14 state boards of osteopathic medicine.

Over the past decade, from 2000 through 2009, the Rhode Island Board has received an average of four hundred complaints per year.

THE RHODE ISLAND BOARD OF MEDICAL LICENSURE AND DISCIPLINE (BOARD)

The Rhode Island Department of Health was established more than one hundred years ago. However, the **Board of Medical Licensure and Discipline (the Board)** and Discipline and the laws governing the practice of medicine, pursuant to General Laws Chapter 5-37, went into effect in 1895. For the next ninety years, the Board has enforced the law in a conservative manner, only seeking to amend the law when necessary and/or desirable. However, in an effort to elevate professional standards of physicians and improve public involvement, a re-organization of the Board was demanded in 1986, resulting in the current Board.

The current Board is unique as compared to other Boards throughout

the nation due to its focus on representing both the interests of physicians and non-physicians in the community. The Board has twelve members, comprising of both physicians and non-physicians and it was the first state board to require half of its members to be non-physicians. The Board is also the only board in the nation to be chaired by a State Director of Health. This diversity gives rise to varied perspectives and knowledge that can desirably improve the Board's ability to make decisions regarding physician misconduct and their grounds for disciplinary action. This ultimately allows the Board to protect the interests of the public from the improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.

COMPLAINT REVIEW PROCESS

All medical complaints against Rhode Island physicians fall within the jurisdiction of the Board. The complaint review process begins with the receipt of a written complaint by the Department of Health. A complaint can originate from a variety of sources including, but not limited to, patients, family members of patients, other licensed professionals and hospitals. At inception, all complaints are confidential, and are reviewed by a small Investigative Committee to determine whether the complaint warrants further investigation by the Board (see General Laws § 5-37-5.2). Complaints that warrant further investigation are assigned to an investigator who collects information on the case and then notifies the physician of the complaint and the pending investigation. As part of this notification, the physician is always given a reasonable opportunity to respond to the complaint in writing and to present additional evidence. When all relevant information has been gathered, the investigator submits his or her recommendation to the Board, along with pertinent facts regarding the complaint for the Board to

make a decision on the case. The Board's members review all findings of fact and law, and a majority vote must exist for an individual to be found guilty of unprofessional conduct, pursuant to General Laws § 5-37-5.1). Once unprofessional conduct is found, the Board has the discretion to administer a variety of sanctions, ranging from reprimand of the physician to indefinite revocation of their license (see General Laws § 5-37-6.3). In addition, Rhode Island State Law requires that all conclusions made by the Board shall be made available to the public (see Department of Health website) and other Medical Boards (see FSMB website).

ANALYSIS OF COMPLAINTS

Over the past decade, from 2000 through 2009, the Rhode Island Board has received an average of four hundred complaints per year. The number of complaints filed with the board is somewhat relative to the overall feeling of well being in the community at large. The complaints tend to increase in difficult economic time. Approximately sixty-percent of the complaints are actually investigated by the board on average. The board concludes that "unprofessional conduct" by the licensee has occurred in less than ten percent of the cases. Another ten percent involve non-disciplinary "letters of concern" in which the board expresses its judgment about issues such as poor communication, documentation and care coordination problems.

Unprofessional conduct, as defined in RI General Laws § 5-37, is broadly defined to include a variety of descriptive behaviors or activities. The statute was designed to give the board the authority to determine the acceptable standards of care and professional behavior. In general terms, the types of complaints involving a finding of "unprofessional conduct" are either acts of physician negligence or acts of intent.

Acts of physician negligence have been the most common types of complaints received by the Board, representing approximately 53% of the total number of complaints filed with the Board since 2000. Physician negligence is broadly defined as the "failure to exercise the level of skill, care, and prudence necessary to prevent patient injury" or that a physician has "deviated from

the accepted standard of medical care." The most common forms of negligence include failing to diagnose and treat medical problems, procedure errors and failing to notify patients of abnormal medical test results.

Acts of physician negligence have been the most common types of complaints received by the Board, representing approximately 53% of the total number of complaints filed with the Board since 2000.

Acts of intent are done with a purpose, knowledge, or substantial certainty that the action is wrong and violates professional responsibility. Examples of acts of intent can include crimes, some of which but not all, arise from the practice of medicine. Practicing while under the influence of alcohol or illicit drugs, and substance abuse or sexual contact in the context of a physician/patient relationship are common examples. An analysis of unprofessional conduct findings of the Board indicates that physician impairment and sexual misconduct represent a disproportionate number as compared to quality of patient care issues. This appears to be the trend of medical and osteopathic boards throughout the states. State regulatory boards tend to impose stiffer sanctions when the malfeasance is intentional.

CONSEQUENCES OF INTENTIONAL AND NEGLIGENT ACTS

The consequences of unprofessional conduct in Rhode Island are proportional to the type of professional misconduct.

The Board attempts to foster evaluation and remediation of physicians through the pathway of the Physician

Health Program at the medical society, education enhancement programs, and ethics courses. The board does not sanction most of the physicians who are involved with the Physician Health Program. However, it is often true that by the time the board learns of problems, it is often too late for remediation only. Many of the dispositions of cases will include suspensions as well as board ordered remediation before re-entry into practice. Over the past ten years, of the physicians who have been *sanctioned* for drug and alcohol related offenses, fifty-percent had their license to practice medicine suspended, ranging from summary suspension to indefinite suspension, fifteen-percent received probation for an average of five-years, and ten percent were required to surrender their license to practice medicine. This is often because of crimes that were committed, patients harmed or the ethical violations were so profound that The statistics for those found to have sexually related offenses had similar consequences. Of these physicians, 50% had their licenses suspended. 12.5% of the physicians sanctioned received probation, most often for a period of five years. Finally, the remaining 12.5% were required to surrender their license to practice medicine within the State of Rhode Island. All violations and sanctions are reported to the National Practitioner Data Bank, where other state boards may view the information. When a physician moves a practice to another state, the reported action will be available to licensing authorities.

CONCLUSION

The Rhode Island Department of Health and the Board of Medical Licensure and Discipline are dedicated to protect the public interest through various avenues, such as the (1) regulation of physicians, (2) investigation of complaints, (2) administration of sanctions for physicians found to have engaged in unprofessional conduct, and (4) reporting of all Board disciplinary action decisions to the public. The collected data is used in assessing the ongoing competence of licensed physicians and to facilitate change in the laws. Such services benefit the Board, health organizations, and independent physicians interested in ensuring improvement in the regulation of the

practice of medicine in Rhode Island. By properly balancing the mutual interest of protecting the public interest, as well as the rights of its physicians, the Board seeks to enhance the overall awareness of the types of misconduct that can occur within the physician community and prevent future occurrences.

REFERENCES

For inquiries regarding references, please contact author.

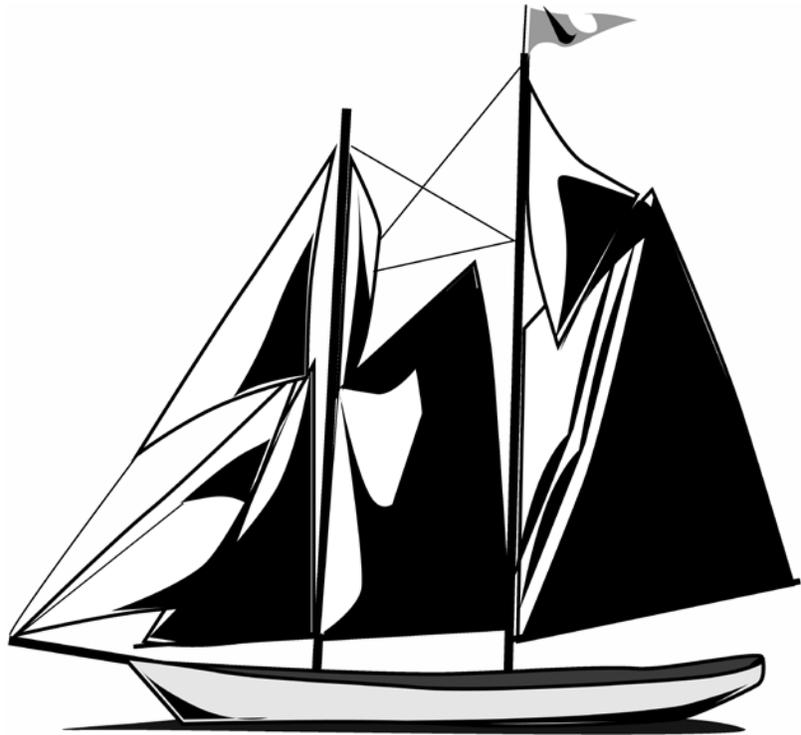
Bruce McIntyre, JD, is Acting Chief Administrative Officer, Board of Medical Licensure and Discipline, Department of Health.

Disclosure of Financial Interests

The author and/or their significant other have no financial interests to disclose.

CORRESPONDENCE

Bruce McIntyre, JD
Department of Health
3 Capitol Hill RM 205
Providence, RI 02908
phone: (401) 222-7890
fax: (401) 222-2158
e-mail: Bruce.McIntyre@health.ri.gov



Dinner & CME Event

Chronic Pain and Opioids: Safe and Effective Management

Date: October 12, 2011
Time: 6.30pm
Location: Crowne Plaza Hotel
At The Crossings
801 Greenwich Ave.
Warwick, RI 02886

RSVP: (401) 276-7500

Space is limited so call today for a reservation.
CME Credits Available.

**NORCAL**
Mutual Insurance Company

INDUSTRY EXPERTISE. PERSONAL SERVICE. A HEALTHIER BOTTOM LINE.

Expect it all.



HEALTHCARE FINANCIAL SERVICES

We take your practice personally.

Our local business bankers know the healthcare industry and will work closely with you to understand the specific needs of your practice. With up to 100% EHR and Healthcare IT financing, and your choice of cash management services, you'll be able to minimize administrative tasks, optimize cash flow, and ultimately, maximize your profits. Call Jace D'Amico at 203.316.5075 to learn more.



WebsterBank.com/ExpectIt



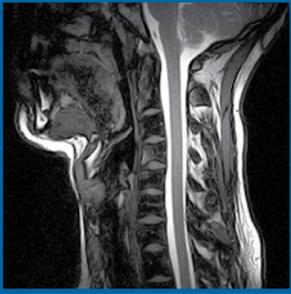
Webster Bank, N.A.
Member FDIC

All credit products and pricing are subject to the normal credit approval process. Some applications may require further consideration and/or supplemental information. Certain terms and conditions may apply. SBA guaranteed products may also be subject to additional terms, conditions and fees. Requires a Webster business checking account which must be opened prior to loan closing and which must be used for auto-deduct of payment. The Webster Symbol and Webster Bank are registered in the U.S. Patent and Trademark Office.



THE IMAGING INSTITUTE

OPEN MRI • MEDICAL IMAGING



High Field MRI

- Offering both 1.5T High Field & Higher Field OPEN MRI Systems

- Advanced CT with multi-slice technology, 3D reconstruction

- Digital Ultrasound with enhanced 3D/4D technology

- Digital Mammography with CAD (computer assisted diagnosis)



MRA



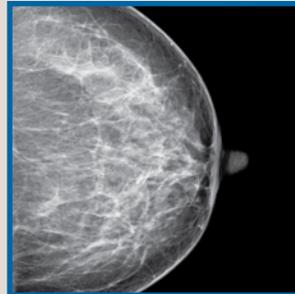
CT • 3D CT



CTA



3D Ultrasound



Digital Mammography



Digital X-Ray & DEXA

- Electronic Medical Record (EMR) Interfaces now available
- Preauthorization Department for obtaining all insurance preauthorizations
- Fellowship, sub-specialty trained radiologists
- Friendly, efficient staff and convenient, beautiful office settings
- Transportation Service for patients



Higher Field OPEN MRI

WARWICK

250 Toll Gate Rd.
TEL 401.921.2900

CRANSTON

1301 Reservoir Ave.
TEL 401.490.0040

CRANSTON

1500 Pontiac Ave.
TEL 401.228.7901

N. PROVIDENCE

1500 Mineral Spring
TEL 401.533.9300

E. PROVIDENCE

450 Vets. Mem. Pkwy. #8
TEL 401.431.0080

Fraud in Health Care and Organized Crime

James F. Dube, JD

FALSE CLAIMS TO MEDICARE AND MEDICAID ARE nothing new. Billions of dollars are being lost in Medicare and Medicaid programs to waste, fraud and abuse. Fraud has been characterized by the FBI as intentional deception or misrepresentation of facts to gain an illegitimate benefit. Abuse has been defined as unnecessary costs associated with actions and services that are inconsistent with accepted practices. There are countless schemes being perpetrated that take advantage of taxpayer dollars on both the state and federal levels. The schemes move from state to state and business to business in an attempt to avoid detection. They run for a limited time, referred to as a “rip-period.” New efforts aimed at helping those in need can also open the door to those seeking ways to take advantage of the system. The Global Medicaid Waiver in Rhode Island indeed will increase home health care and assist many people in a very positive way; however, it also undoubtedly will open up opportunities for fraudulent activity in that area. This article highlights some of the fraud risks in Rhode Island, as well as the state-level protections we have implemented to prevent it. Finally, we offer some recommendations to Rhode Island health care providers on how to avoid being ensnared in the local and federal law enforcement apparatus.

To compound matters, it isn't simply just individuals seeking to take advantage of the system. New organized groups are finding that health care fraud schemes are far less dangerous and more lucrative than other more dangerous crimes such as drug trafficking and the like. Health care fraud has grown over the years. As new people turn to crime, different schemes are uncovered. The fraud across the country is found in many different areas of practice. There are cases involving doctors, dentists, chiropractors, nurses, home health care aides, personal care attendants, nursing homes, ambulance companies, etc. If someone can think of a new way to perpetrate a fraud on our system, they give it a try. If successful, they keep on billing an already burdened system during a “rip-period,” then suddenly stop and move on to another scheme at a different location.

On the state side, the single-state agency through which the Medical Assistance Program is administered is the Rhode Island Department of Human Services (DHS).

The Rhode Island Department of Attorney General's Medicaid Fraud and Patient Abuse Unit (MFCU) investigates many complaints and offenses. Among those, are allegations of fraud being perpetrated upon the system by individuals, corporations or other groups. The MFCU consists of two attorneys (Unit Chief / Director and Deputy Director), a case coordinator/paralegal, one chief investigator, one nurse investigator, one auditor, and five additional investigators. The MFCU handles both civil and criminal matters in the fight against fraud and abuse. Many investigations are opened through routine investigative efforts and complaints while others are started after billing anomalies are detected through data analysis and the use of various algorithms.

Now, a new purveyor of fraud in health care has emerged. Organized crime has started to become involved in Medicaid and Medicare fraud.

The Attorney General's Office works closely with the United States Attorney's Office for the District of Rhode Island, as well as federal investigators from **United States Department of Health and Human Services, Office of Inspector General, Office of Investigations** (HHS OIG OI), the FBI, the FDA, and other agencies to uncover and prosecute these cases.

Recently, the MFCU Director, a Rhode Island State Assistant Attorney General, has been cross-designated as a Special Assistant United States Attorney

in order that cases could be prosecuted jointly by both agencies. The entry of the state into the federal prosecution system also assists in allowing the state the use of the greater federal resources in the fight against fraud. The HHS administers the Medicare program. It may be hard to imagine, however, that the budget for HHS¹ is approximately 100 billion dollars larger than that of the United States Department of Defense,² with two wars going on. This information serves to illustrate the immense budget and taxpayer dollars at stake. Such a large amount of funds requires extraordinary protection from those seeking to abuse it. Those of us charged with that duty are making a coordinated and dedicated effort to afford that protection and seek out and prosecute the offenders.

Now, a new purveyor of fraud in health care has emerged. Organized crime has started to become involved in Medicaid and Medicare fraud. False claims and exaggerated claims have been occurring right along by individuals and groups, but now, criminal organizations are in the mix. Identity theft is playing a large role in the schemes being conducted. Russians, Nigerians and Armenian gangs have been arrested in Los Angeles by federal authorities for scamming millions of dollars from the health care system. There are also other groups from Cuba, Philippines, Ukraine, Mexico, Italy, as well as those from the United States, including street gangs getting involved in health care fraud. These groups are turning to health care fraud because it is lucrative, not physically dangerous and there is only a small capital investment that is required to get started.

Millions of Americans depend on Medicaid and Medicare and efforts are being made to protect these programs.

In May 2009, United States Attorney General Eric Holder and HHS Secretary Kathleen Sebelius announced the creation of the **Health Care Fraud Prevention and Enforcement Action Team (HEAT)** and renewed their commitment to fighting health care fraud as a Cabinet-level priority at both departments.

The mission of HEAT is clear:

- To marshal significant resources across government to prevent waste, fraud and abuse in the Medicare and Medicaid programs and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars.
- To reduce skyrocketing health care costs and improve quality of care by ridding the system of perpetrators who are preying on Medicare and Medicaid beneficiaries.
- To highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud and abuse in Medicare.
- To build upon existing partnership that already exists between the two agencies, including our Medicare Fraud Strike Forces to reduce fraud and recover taxpayer dollars.³

Since the federal government began with the HEAT Task Force, they have charged over 800 defendants with defrauding Medicare of nearly 1.9 million taxpayer dollars.⁴

Providers must be cognizant of the importance of protecting patient demographics. Identity theft from patients' files can lead to major losses in the health care system. The theft of patient identities brings fraudulent billing for goods and services and many other abuses and fraud-

ulent schemes. Providers must vigilantly protect that information from those who would illegally seek it. Prospective medical employees with access to such information should be thoroughly screened to fill such positions. Office and other medical staff should be on the lookout for co-workers making unauthorized copies of patient demographic information.

The state and federal governments are making greater efforts to protect the system, including the Affordable Care Act. New legislation is being sought and enacted to assist in the prosecution of the types of crimes discussed. Existing statutes, such as **Racketeer Influenced Corrupt Organizations (RICO)** are and will be added to charges where appropriate to enhance penalties of those convicted of such crimes. Strike Forces are being formed throughout the country along with training and outreach efforts being employed and proposed in an attempt to significantly reduce health care fraud.

Some suggestions to help avoid fraud investigations would include staff training of proper coding and billing procedures. Sometimes, physicians can have staff billing incorrectly without even knowing it. It is, however, the physician who is ultimately held responsible. Unbundling, billing for procedures citing the wrong location, i.e. in-office procedure billed inadvertently as performed at a facility and other ministerial errors. It would also be prudent to review your systems to make sure that all patient information, both hard copy and electronic, is protected

from improper access to protect against HIPPA violations as well as medical identity theft.

Finally, physicians should protect their own information and be wary of unscrupulous individuals seeking to use their credentials to conduct fraudulent schemes.

If you suspect fraud or abuse in health care, please report it. In addition to making sure that the funds will be there for those who need the help from this system, it is all of our tax dollars that we are working to protect.

REFERENCES

1. www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf.
2. www.budget.mil.
3. <http://blogs.usdoj.gov/blog/archives/934>.
4. <http://blogs.usdoj.gov/blog/archives/934>.

James F. Dube, JD, is an Assistant Attorney General, and Director of the Rhode Island Medicaid Fraud and Patient Abuse Unit.

Disclosure of Financial Interest

The author and/or their significant other have no financial interests to disclose.

CORRESPONDENCE

James F. Dube, JD
RI Department of Attorney General
150 South Main St.
Providence RI 02903
phone: (401) 274-4400 x2410
e-mail: jdube@riag.ri.gov



HAYES & SHERRY
REAL ESTATE SERVICES

1275 Wampanoag Trail | E.Providence, RI

**NEWLY RENOVATED
MEDICAL OFFICE/PROFESSIONAL SPACE**

Offering:

- 4,500sf - lower level
- 3,000sf & 10,000sf -1st flr.
- 2,500sf & 7,500sf -2nd flr.
- Turnkey buildouts available
- Ample Parking
- Close to hospitals
- Handicap accessible
- Negotiable rates & pricing

Please call for additional information or to arrange a tour of this property:

Mick Hogan
MHogan@hayessherry.com
Ph.401.273.1980

Hayes & Sherry Real Estate Services • Providence, RI • www.hayessherry.com

On Tombstone

Vlad Zayas, MD

POOR COUNTESS. AND, YES, POOR DR. SNEGIREV. IT IS ONE thing is to have an unhappy patient rate you poorly on the internet site, or to have your nod toward an unconventional therapy published in the local newspaper, and quite another—to have a negative surgical outcome to be immortalized on a tombstone.

Since childhood, I was fascinated by this tombstone in Donskoi Monastery in Moscow, Russia. Somehow, the Monastery and the graveyard survived almost unmolested the decades of the Soviet era. The graveyard was a common burial place for Moscow aristocracy since the 18th century.

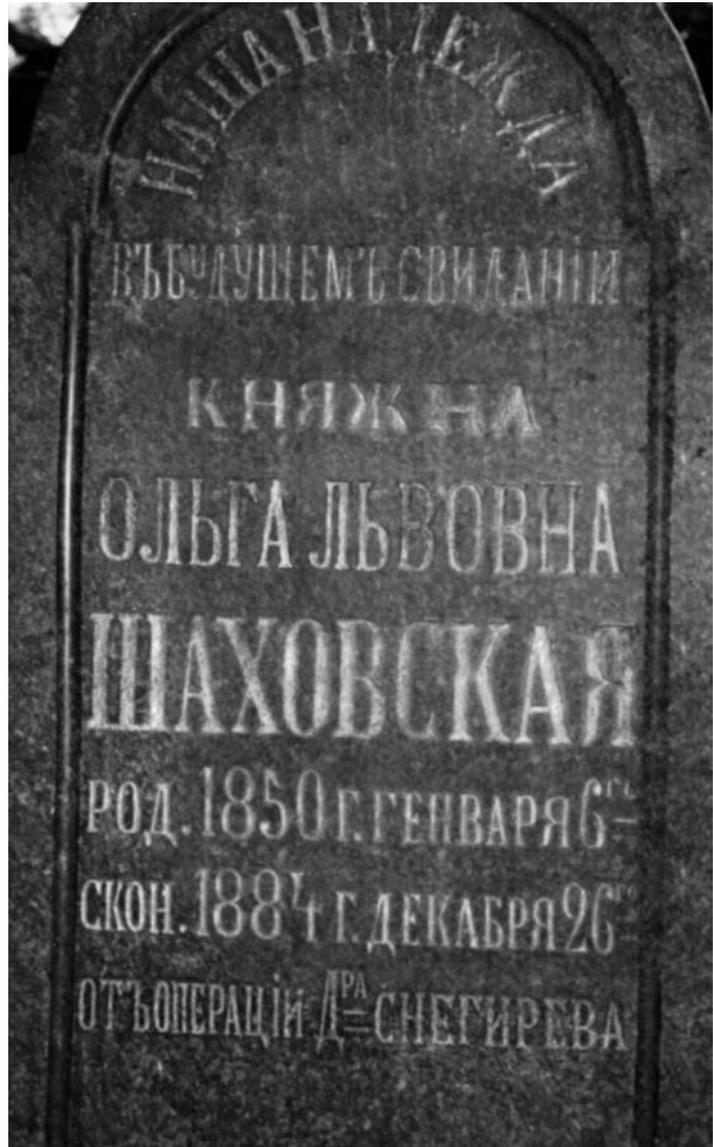
Who was poor Dr. Snegirev? I am not the only one wandering about this. Russian writer Grigory Chkhartashvili in his book *Graveyard Stories* imagines an unhappy ghost in a white lab coat haunting the graveyard in Donskoi Monastery. Probably, it was Vladimir Fiodorovich Snegirev (1847-1917), Professor of Obstetrics and Gynecology. He is frequently referred to as a founding father of the Russian OBGYN school. His illustrious academic career is beyond the purpose of this brief report. Several authors mention the case of the countess *en passant*. In Dr. Snegirev's biography published in 1950 the author includes a photograph of the tombstone offering no details of the case. The most convincing fact, though, is something V.F. Snegirev said in his speech at the First Congress of the Russian Society of Obstetricians and Gynecologists in 1904. The speech itself is quite fascinating. It summarizes successes and failures of his 30 years in practice. Close to the end of the speech, while describing the lack of trust of the patients in their surgeons, he laments: "...sometimes they went as far as putting tombstones on the graves, announcing 'under this rock lies body N. cut down by the surgeon N.!' (Translated by the author).

It is possible that it was V.F. Snegirev himself immortalized on this tombstone. It is possible, however, that there are some medical records waiting to be discovered to provide the proof for this speculation.

Vlad Zayas, MD, is an Clinical Associate Professor in the Department of the Neurosciences, The Warren Alpert Medical School of Brown Universit

CORRESPONDENCE

Vlad Zayas, MD
450 Veterans Memorial Pkwy, Bldg 11
East Providence, RI 02914
phone: (401) 431-1860
e-mail: drvzayas@yahoo.com



COUNTESS
OLGA LVOVNA
SHAKHOVSKAYA
BOURNE JANUARY 6, 1850
DIED DECEMBER 26, 1884

AFTER THE SURGERY PERFORMED BY DR.SNEGIREV



Assessment and Management of Pain in a Resident Medical Clinic

Katherine Fox, MD, Brian Hollenbeck, MD, Katherine Moore, MD, Helena Walsh, MD, and Mark Schleinitz, MD

MANAGEMENT OF A PATIENT'S PAIN IS AN IMPORTANT GOAL IN OUTPATIENT primary care offices. Increasingly, panels such as The **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** include pain assessments as a marker for quality of care. A physician's ability to recognize pain and document pain management plans has important implications for accreditation and reimbursement, as well as patient outcomes.

The identification of pain, often referred to as the fifth vital sign, is now standardized by a visual analog scale. This score is documented upon each clinic encounter. The question arises as to whether the clinician is responding to this score and if there are variables that affect such acknowledgement, documentation, and management.

In the resident-run **Medical Primary Care Unit (MPCU)** at Rhode Island Hospital, nurses address pain upon patient intake using the standardized pain scale and document it in on the patient encounter form. In November 2009, a change was implemented with the goal of improving both assessment and management of pain. This change entailed the nurse asking the patient to localize their pain, and documenting the location on the intake sheet with the hopes of facilitating the clinician's acknowledgment of the pain.

Table 1. Patient Characteristics (pre and post intervention combined)

Age +/- Range	47.9 (18 – 78)
Male	38 (42.7%)
Female	51 (57.3%)
Caucasian	40 (45%)
African American	30 (33.7%)
Hispanic	37 (41.6%)
Other	10 (11.2%)
English speaking	49 (55%)
Uninsured	13 (14.6%)
Average number of problems addressed / visit +/- standard deviation (SD)	4 +/- 1.7
Psychiatric Disease	39 (43.8%)
Patients with history of Alcohol or substance abuse	22 (24.7%)
Average Number of providers seen in study period +/- SD	3 +/- 1.7

METHODS

In a quality improvement study, for which Rhode Island Hospital IRB approval was obtained, we reviewed the impact of the above intervention on physician's ability to address and document pain management in continuity notes. Our primary outcome was the acknowledgment of the patient's pain in the assessment and plan of the clinic encounter form in compliance with JCAHO guidelines. Specifically, we noted if "pain" was addressed in the assessment and plan or if the problem listed in the assessment and plan clearly linked the disease process to the pain (e.g. osteoarthritis causing knee pain). As a secondary analysis, we examined whether a variety of demographic data and patient factors (stated below) influenced whether or not pain was addressed in the assessment and plan.

Primary and secondary outcomes were assessed using random chart review for a two year period between Sept 1, 2008 and Sept 1, 2010. This time period was then divided into the pre-intervention period (before November 2009) and post-intervention. If there was an encounter between Sept 1, 2008 and November 2009 and a different encounter between Nov 2009 and Sept 2010, those visits were both included. Multiple encounters between either of the two specified periods resulted in one encounter being chosen at random. Exclusion criteria included patients on a pain contract or those without pain greater than four on a one-to-ten pain scale. A variety of demographic and patient characteristics were collected, including gender, age, ethnicity, race, spoken language, insurance status, history of alcohol or substance abuse and psychiatric disease, chief complaint of the patient encounter, number of problems addressed at each visit, and measurements of continuity. These characteristics were then analyzed to identify any possible confounders or associations (as a secondary outcome).

The pre-intervention data was analyzed separately from the post-intervention data, thus precluding the need for each chart to have both a pre and post intervention encounter. For both primary and secondary analysis, chi-square analysis was used to determine the rate of effectiveness of the intervention in obtaining at least one of the two outcomes. Inter-rater variability was calculated using an ANOVA calculator.

RESULTS

135 charts were reviewed. 46 charts were excluded because there were no visits with a pain scale ≥ 4 . 89 charts were included which yielded 73 pre-intervention and 52 post intervention encounters, totaling 125 encounters. 65.9% of sampled clinic

Table 2. Chi-square analysis of primary and secondary outcomes.

Variable (n)	Number (%)	Odds Ratio	P value
Post-intervention	52 (69.2)	0.85	0.7
Pre-intervention	73 (65.7)		
Male	54 (64.8)	1.2	0.7
Female	71 (69.0)		
Good continuity	43 (58.1)	1.847	0.16
Bad continuity	82 (71.9)		
Substance abuse	35 (57.0)	1.85	0.14
No substance abuse	90 (71.0)		
Psychiatric disease	54 (62.9)	1.4	0.44
No psychiatric disease	71 (70.4)		
White	57 (64.9)	1.2	0.7
Non-white	68 (69.1)		
English speaking	67 (59.7)	2.12	0.059
Non-English speaking	58 (75.8)		
Uninsured	22 (72.7)	0.73	0.62
Insured	103 (66.0)		
Pain 4-7	72 (72.2)	0.58	0.18
Pain 8-10	53 (60.4)		
Pain as chief complaint (CC)	31 (93.5)	0.09	0.0003
Pain is not C.C.	94 (58.5)		
Age > 65	12 (66.6)	1.027	1.0
Age <65	113 (67.2)		
4+ problems / visit	70 (72.8)	0.558	0.17
1-3 problems / visit	55 (60.0)		
3+ providers	103 (70.8)	0.41	0.079
1-2 providers	22 (50.0)		
Hispanic	53 (73.5)	0.59	0.25
Non-Hispanic	72 (62.5)		

population reported at least 4/10 pain on at least one visit during the study period dates, and 42.4% had severe pain (8/10 or higher). No patients in the study sample were under a narcotic contract. Average age was 47.9, 57.3% female, 42.7% male, average number of providers seen during study period was 3.28. Additional demographic data are featured in Table 1.

There were 125 patient-encounters included in analysis of the primary and secondary outcomes. Among all encounters, before and after the intervention, the primary outcome was met 66% of the time. Nurses adhered to the intervention strategy 85% of the time.

In chi-square analysis, the quality improvement initiative was not found to make a statistically significant impact on the primary outcome (69% vs. 65%, $P=0.7$). Among all characteristics studied in the secondary outcome, only “chief complaint mentioning pain” was associated with a positive primary outcome (94% vs. 59%, $P=0.0003$). Additional secondary outcome findings are listed in Table 2. ANOVA calculations for inter-rater reliability showed no statistical difference between researchers when measuring the primary outcome during either the pre-intervention period ($p=0.49$) or the post-intervention period ($p=0.99$).

DISCUSSION

Our research indicates that our intervention was not successful in increasing pain documentation compliance. This may be due to the fact that our compliance at the outset was better than expected, or may be a function of the loosely defined definition of what constituted a positive encounter within the pre-intervention data—thus elevating the rate of compliance overall. A higher powered study and more clearly defined pre-intervention criteria may further demonstrate this effect.

Prior to our intervention, pain was addressed at a surprisingly high rate of nearly 70%.

The only variable that was statistically significant in augmenting the rate at which pain was addressed was if the chief complaint of the encounter was centered around a primary pain issue. No other measured variable impacted assessment and management of pain. It appears MPCU clinicians may be better at addressing pain in patients who are not in their continuity pool, as indicated by the large, though non-statistically significant difference in outcome in the low continuity patients compared with the high continuity patients.

In order to further increase compliance with pain documentation and management, our group recommends an education session for clinicians in the MPCU to discuss pain management goals, policies, and procedures. In addition, educating the clinic population on the MPCU’s pain management goals may also result in patients who are more assertive regarding their pain management needs.

Pain is recognized as the fifth vital sign, and is an important component to patients’ medical illness, and overall well being. JCAHO has standardized the documentation of pain, and has indicated pain assessment as a quality of care indicator. In the MPCU, we found that physicians address pain at a high rate overall, but our quality improvement initiative was not able to further increase compliance with JCAHO recommendations.

REFERENCES

1. *Approaches to Pain Management. Joint Commission on Accreditation of Health-care Organizations. Second Edition.* November 2010. www.jointcommission.org.
2. Yadgood MC et al. Relieving the agony of the new pain management standards. *Am J Hosp Palliat Care.* 2000 Sep-Oct;17(5):333-41.
3. Phillips, D. JCAHO Pain Management Standards Are Unveiled. *JAMA.* 2000;284(4):428.

Katherine Fox, MD, is a 2011 graduate of the Warren Alpert Medical School of Brown University General Internal Medicine Residency Program. She is currently a palliative care fellow at Montefiore Medical Center in the Bronx, New York.

Brian Hollenbeck, MD, is a graduate of the Warren Alpert School of Medicine at Brown University's Internal Medicine Residency Program, and is currently serving as a Chief Medical Resident.

Katherine Moore, MD, is a 2011 graduate of the Brown/Rhode Island Hospital General Internal Medicine Residency, and currently working at the University of Kansas Hospital in the Dept. of General Internal Medicine.

Helena Walsh, MD, is a graduate of the Warren Alpert School of Medicine at Brown University's Internal Medicine Residency Program, and is currently employed in the Division of Hospital Medicine at Rhode Island Hospital.

Mark Schleinitz, MD, is Associate Professor of Medicine at the Warren Alpert School of Medicine of Brown University. He is Director of Resident Research and supervises the Quality Improvement Clerkship for 2nd year residents at Rhode Island Hospital.

Disclosure of Financial Interest

The authors and/or their significant others have no financial interests to disclose.

CORRESPONDENCE

Katherine Moore, MD
e-mail: kt881@yahoo.com

Information for Contributors

Medicine & Health/Rhode Island is peer-reviewed, and listed in the *Index Medicus*. We welcome submissions in the following categories:

CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island: new research, treatment options, collaborative interventions, review of controversies. Maximum length: 2500 words. Maximum number of references: 15. Tables, charts and figures should be submitted as separate electronic files (jpeg, tif, or pdf).

CREATIVE CLINICIAN

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6. Photographs, charts and figures may accompany the case.

POINT OF VIEW

Readers share their perspective on any issue facing clinicians (e.g., ethics, health care policy, relationships with patients). Maximum length: 1200 words.

ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1200 words.

ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1200 words.

IMAGES IN MEDICINE

Authors submit an interesting Image, with a 300-400 word explanation.

For the above articles: Please submit an electronic version (Microsoft Word or Text) with the author's name, mailing address, phone, fax, e-mail address, and clinical and/or academic positions to the managing editor, John Teehan, e-mail: jtteehan@rimed.org. For additional information, phone: (631) 903-3389. Faxes may be sent to (401) 826-1926.

HELP WANTED, SPACE TO LEASE, OR EQUIPMENT TO SELL?



Whether you are a RIMS member or not, you can post all of the particulars of your message on the Medical Society's website – **Classified Ads Section** – for a very reasonable rate. Purchase ad space in *Medicine & Health/RI* and your online classified ad is **FREE**.

Your ad will run for four weeks, with discounted rates for multiple months. We will link your ad to your email address or website for easy replies. For more information, please visit www.rimed.org or contact Cheryl Turcotte at RIMS: 401-331-3207.



The Creative Clinician

Synovial Chondromatosis

N. Peter Libbey, MD, and Franklin Mirrer, MD

LOOSE BODIES IN THE JOINT SPACE MAY BE DUE TO A NUMBER OF conditions. Loose bodies composed primarily of fibrin, “rice bodies”, are due to bleeding into the joint or to synovitis as in rheumatoid arthritis or tuberculosis.¹ Cartilaginous or osteocartilaginous loose bodies are most commonly secondary to injury to the joint cartilage from trauma or fracture, or degeneration of the cartilage as in osteoarthritis or osteochondritis desiccans.² **Synovial chondromatosis (SC)**, sometimes referred to as primary synovial chondromatosis, is a rare disorder in which cartilaginous or osteocartilaginous loose bodies, usually in large numbers, form in the joint space without an apparent underlying injury to the cartilage or synovium.² Although morphologic overlap with the secondary types may occur, the histopathologic features of loose bodies in SC are usually distinctive, allowing the pathologist to identify them as such, whereas the clinical findings may be ambiguous. Herein we describe a case of SC with typical morphologic and clinical features.

CASE REPORT

A 45 year-old male plumber presented with a two-month history of knee pain, swelling and stiffness. He recalled no injury to the knee, only worsening symptoms over time, and there was no history of preexisting arthritis or joint disease. On physical examination, he had a large joint effusion, which was aspirated, yielding 20-30 cc of serous fluid and resulting in immediate improvement in his symptoms and range of motion. There was no instability of the cruciate, collateral or posterolateral corner ligaments, but the examination elicited symptoms of a probable medial meniscus tear and mild patellofemoral pain. The distal nerve and vascular examination was normal. **Magnetic resonance imaging (MRI)** of the knee confirmed the presence of an extensive tear of his medial meniscus as well as mild degenerative change in his medial and patellofemoral compartments. The patient elected to have arthroscopic repair of the meniscus tear, during which numerous loose bodies, possibly 250 or more, each measuring between two and ten millimeters in greatest dimension, were encountered in the joint space (Figure 1. Arthroscopic image). These were removed by aspiration and lavage, the medial meniscus tear as well as an unsuspected tear of the lateral meniscus were repaired, and the entire synovium, which appeared to be inflamed or reactive, was removed. No injury of the cartilage or patellofemoral joint was identified. A sample of the loose bodies and synovium was submitted for pathologic examination. The patient recovered uneventfully from his surgery, but he eventually developed recurrent pain and effusions in the knee and underwent a second arthroscopic procedure 14 months after his initial operation.

PATHOLOGIC FINDINGS

The specimen obtained from the first operation consisted of about twenty-five ivory-colored cartilaginous nodules, each four to five millimeters in diameter with a smooth, slightly

lobular surface. Microscopically, the nodules were composed of hyaline cartilage matrix containing lobular clusters of chondrocytes (Figure 2). Each of the nodules was surrounded by a shaggy rim of fibrin or a thin mantle of synovium, which occasionally enclosed several coalescing nodules. The chondrocytes displayed mild-to-moderate variation in nuclear size and configuration (Figure 3). A rare nodule demonstrated focal peripheral endochondral bone formation. The specimen from the second procedure contained similar cartilaginous nodules with more extensive ossification as well as a few fragments of hyalinized synovium.

DISCUSSION

In contrast to those that develop secondary to cartilaginous injury, which typically have a concentric lamellar matrix surrounding a nidus of ossified cartilage, the loose bodies of SC have a distinctive lobular configuration with clusters of mildly-to-moderately atypical chondrocytes in a chondroid matrix as

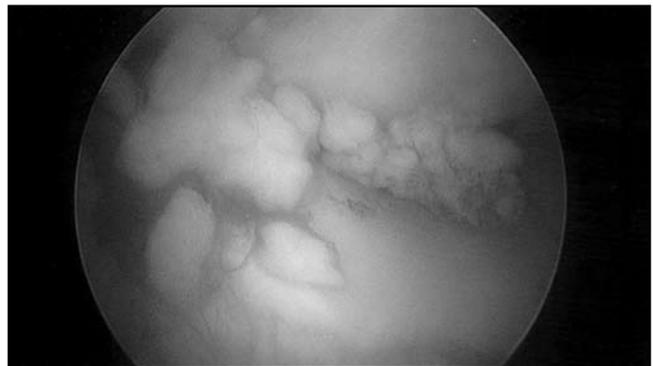


Figure 1. Arthroscopic image of intraarticular loose bodies.

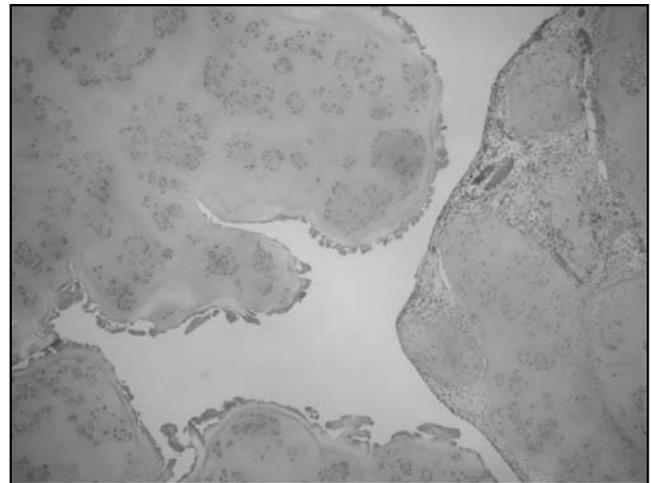


Figure 2. Cartilaginous nodules with lobular arrangement of chondrocytes in hyaline cartilage matrix and surface covered with layer of fibrin or thin mantle of synovium (right).

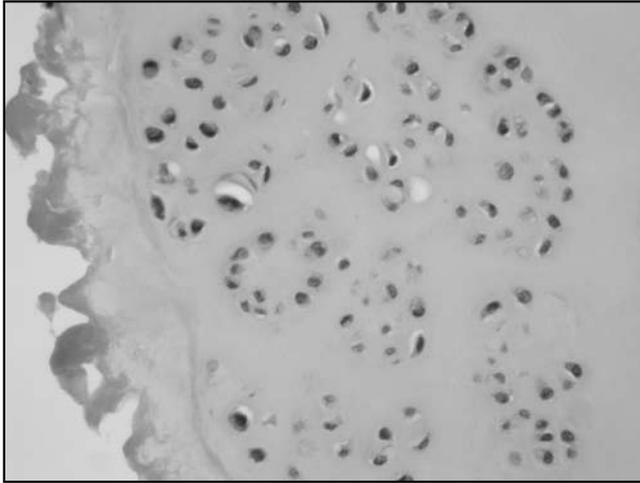


Figure 3. Chondrocytes showing lobular arrangement and mild-to-moderate nuclear atypia.

seen in this case. As the disease progresses, the cartilaginous bodies break free of the synovium eventually becoming ossified. What initiates the disease is not known, although the cartilaginous nodules are believed to develop within the synovium from chondrocytic metaplasia of fibroblasts, perhaps with the influence of **transforming growth factor-beta (TGF- β)** and **bone morphogenic proteins (BMP)**, both of which have been identified in lesional tissue.^{3,4,5} Attempts to identify a genetic event associated with the development of SC so far have yielded inconsistent results,^{6,7} leaving open the question of whether the lesion is neoplastic rather than simply metaplastic in nature; however, malignant transformation of SC, usually to a form of chondrosarcoma with aggressive behavior, is seen in about 5% of cases.⁸

SC usually affects a single large joint, most often the knee or hip, but any joint may be involved, including the joints of the hand and foot or the temporomandibular joint. Roughly twice as many men as women develop SC, and it is rare in children, the average age at presentation being 41 years.⁸ SC is often difficult to detect by x-ray or MRI in the early stages before the cartilaginous nodules become ossified.⁹ Although the symptoms of SC may mimic those of a torn meniscus,¹⁰ the significance of the meniscal tear in this case is uncertain. It has not been previously identified as an associated or complicating factor in SC and may be coincidental. About 5% of patients eventually develop osteoarthritis in the affected joint.⁸

Arthroscopic or open removal of the loose bodies, with or without complete synovectomy, is usually successful in treating SC. Five (11.1%) of 45 knees in 42 patients so treated in two studies required a second arthroscopic procedure.^{11,12} Twenty-three (20.7%) of 111 patients with SC of the hip, 69 of whom had arthroscopy only, required further arthroscopy for recurrence; twenty-two (19.8%) of the 111 patients eventually went on to have total hip replacement.¹³ Arthroplasty may provide significant symptomatic relief, but SC recurred in 1 of 4 (25%) knee and 1 of 7 (14%) hip replacement patients followed by Ackerman et al.¹⁴ Interestingly, radiation therapy has been reported to be successful in the treatment of one case of refractory SC of the knee,¹⁵ but caution regarding this would seem to be advisable.

REFERENCES

1. Tyllianakis M, Kasimatis G, Athanaselis S. Rice-body formation and tenosynovitis of the wrist: a case report. *J Orthoped Surg.* 2006;14(2):208-11.
2. O'Connell JX. Pathology of the synovium. *Am J Clin Pathol.* 2000;114:773-84.
3. Fujita S, Iizuka T, Yoshida H, Segami N. Transforming growth factor and tenascin in synovial chondromatosis of the temporomandibular joint. Report of a case. *Int J Oral Maxillofac Surg.* 1997;26(4):258-9.
4. Watson RS, Gouze E, Levings PP, Bush ML, et al. Gene delivery of TGF-1 induces arthrofibrosis and chondrometaplasia of synovium in vivo. *Lab Invest.* 2010;90(11):1615-27.
5. Nakanishi S, Sakamoto K, Yoshitake H, Kino K, et al. Bone morphogenic proteins are involved in the pathobiology of synovial chondromatosis. *Biochem Biophys Res Commun.* 2009;379(4):914-9.
6. Mertens F, Jonsson K, Willen H, et al. Chromosome rearrangements in synovial chondromatous lesions. *Br J Cancer.* 1996;74:251-4.
7. Sciot R, Dal Cin P, Bellemans J, Samson I, et al. Synovial chondromatosis: clonal chromosome changes provide further evidence for a neoplastic disorder. *Virchows Arch.* 1998;433:189-91.
8. Davis RI, Hamilton A, Biggart JD. Primary synovial chondromatosis: a clinicopathologic review and assessment of malignant potential. *Hum Pathol.* 1998;29(7):683-8.
9. Knoeller SM. Synovial osteochondromatosis of the hip joint. Etiology, diagnostic investigation and therapy. *Acta Orthoped Belg.* 2001;67(3):201-10.
10. Lin RC, Lue KH, Lin ZI, Lu KH. Primary synovial chondromatosis mimicking medial meniscus tear in a young man. *Arthroscopy.* 2006;22(7):803.e1-3.
11. Dorfmann H, DeBrie B, Bonvarlet JP, Boyer Y. Arthroscopic treatment of synovial chondromatosis of the knee. *Arthroscopy* 1989;5(1):48-51.
12. Samson L, Mazurkiewicz S, Treder M, Wisniewski P. Outcome in the arthroscopic treatment of synovial chondromatosis of the knee. *Ortop Traumatol Rehabil* 2005;7(4):391-6.
13. Boyer T, Dorfmann H. Arthroscopy in primary synovial chondromatosis of the hip: description and outcome of treatment. *J Bone Joint Surg Br* 2008;90(3):314-8.
14. Ackerman D, Lett P, Galat DD Jr, Parvizi J, Stuart MJ. Results of total hip and total knee arthroplasties in patients with synovial chondromatosis. *J Arthroplasty* 2008;23(3):395-400.
15. Chong CC, Kneebone A, Kirsh G. Radiotherapy in the management of recurrent synovial chondromatosis. *Australas Radiol* 2007;51(1):95-8.

Dr. Libbey is an Associate Pathologist at Roger Williams Medical Center and Clinical Associate Professor of Pathology at Boston University School of Medicine.

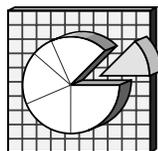
Dr. Mirrer is an Orthopedic Surgeon in Warwick, RI.

Disclosure of Financial Interest

The authors and/or their significant others have no financial interests to disclose.

CORRESPONDENCE

N. Peter Libbey, MD
 Department of Pathology
 Roger Williams Medical Center
 825 Chalkstone Avenue
 Providence, RI 02905
 phone: 401.456.2162
 fax: 401.456.2131
 e-mail: plibbey@rwmc.org



Multivitamin Use prior to Pregnancy in Rhode Island

Hyun (Hanna) Kim, PhD, Rachel Cain, BA, and Samara Viner-Brown, MS, Mei-Fen Yang

EACH YEAR IN THE UNITED STATES, AN estimated 3,000 pregnancies are affected by **neural tube defects (NTDs)**, including spina bifida (an incomplete closure of the spinal cord and spinal column) and anencephaly (severe underdevelopment of the brain).^{1,2} NTDs are among the most common birth defects that contribute to perinatal mortality, infant mortality, and serious disability in surviving children.² Research indicates that daily consumption of 400 mcg of folic acid before pregnancy through the first trimester can reduce the occurrence of NTDs by 50%-70%, and some birth defects other than NTDs.^{1,2,3} Although folic acid can be obtained from foods rich in naturally occurring folates or fortifying foods, not all women obtain adequate levels of folic acid through their diets. Therefore, the **United States Public Health Service (PHS)** and **Centers for Disease Control and Prevention (CDC)** recommend that all women of childbearing age who are planning on or capable of becoming pregnant take a daily multivitamin, which generally contains the recommended daily allowance of 400mcg of folic acid, to reduce their risk of having a pregnancy affected with NTDs.³

The purpose of this report is to 1) describe the trends in daily use of multivitamins prior to pregnancy among Rhode Island women with a live birth, and 2) identify disparities in preconception multivitamin use among subpopulations.

METHODS

Data from the Rhode Island **Pregnancy Risk Assessment Monitoring System (PRAMS)** were analyzed to assess the multivitamin use prior to pregnancy in Rhode Island. PRAMS, a surveillance project of the CDC and state health departments, collects state-specific, population-based data on maternal behaviors and experiences before, during, and after delivery of a live infant.⁴ The PRAMS

sample of women who have had a recent live birth is drawn from the state's birth certificate file.⁴ Rhode Island has participated in PRAMS since 2002, and about 1,400 recent mothers respond to the survey each year.

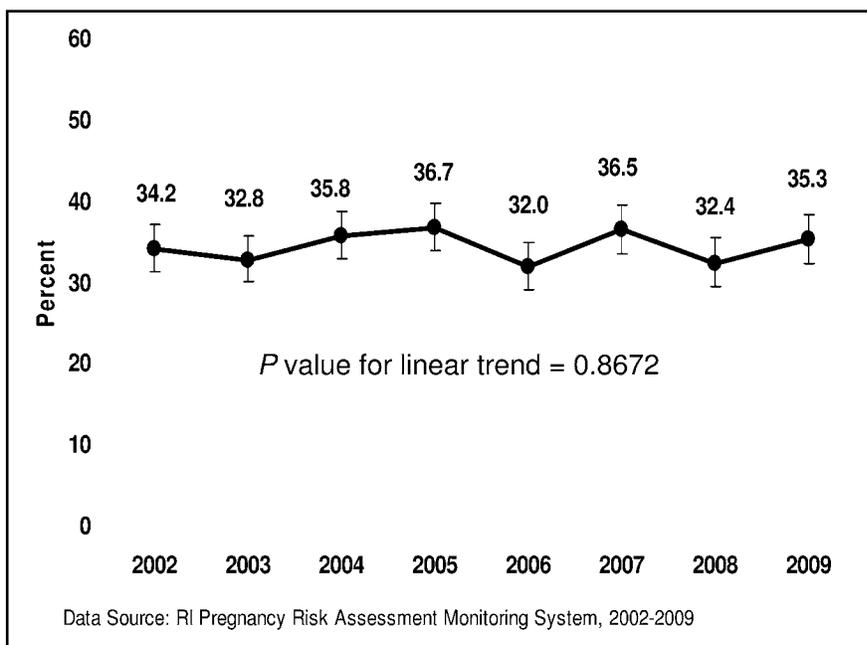


Figure 1. Trends in Daily Use of Multivitamin prior to Pregnancy among Rhode Island Women with a Live Birth, 2002-2009.

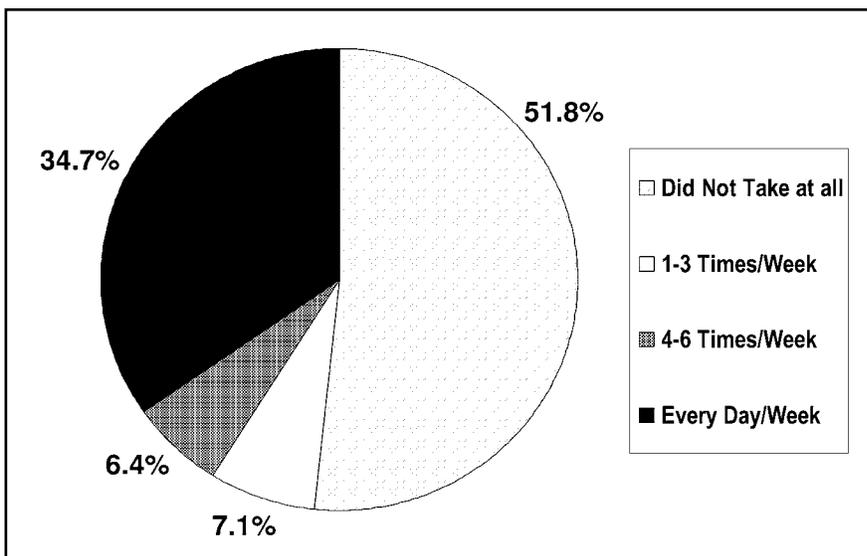


Figure 2. Multivitamin Use prior to Pregnancy among Rhode Island Women with a Live Birth, 2004-2008.

Table 1. Prevalence of Daily Multivitamin Use Prior to Pregnancy by Selected Characteristics, Rhode Island, 2004-2008 PRAMS

	Sample Size ¹	% Daily Multivitamin Use	95% CI ²	P-Value
Overall	6935	34.7	(33.4 - 36.1)	
Maternal Age				<0.0001
< 20	674	21.6	(18.1 - 25.6)	
20-24	1385	19.1	(16.8 - 21.7)	
25-29	1727	32.5	(29.9 - 35.1)	
≥ 30	3149	46.2	(44.1 - 48.3)	
Maternal Ethnicity				<0.0001
Hispanic	1516	25.4	(22.9 - 28.0)	
Non-Hispanic	4401	36.3	(34.7 - 38.0)	
Maternal Race				<0.0001
White	5615	36.1	(34.6 - 37.6)	
Black	710	24.1	(20.5 - 28.1)	
American Indian	96	20.2	(12.3 - 31.3)	
Asian/Pacific Isl.	305	37.6	(31.2 - 44.6)	
Maternal Education				<0.0001
< High School	1142	25.1	(22.2 - 28.2)	
High School	1935	23.1	(21.0 - 25.4)	
> High School	3574	44.5	(42.6 - 46.4)	
Household Income				<0.0001
< \$25K	2504	21.1	(19.3 - 23.1)	
\$25K - <\$50K	1215	30.2	(27.2 - 33.3)	
≥ \$50K	2517	50.5	(48.3 - 52.8)	
Marital Status				<0.0001
Married	4160	44.0	(42.2 - 45.7)	
Not married	2775	21.1	(19.4 - 23.0)	
Insurance before Pregnancy				<0.0001
No Insurance	1403	17.3	(15.1 - 19.8)	
Public	1514	25.5	(23.0 - 28.2)	
Private	4000	44.0	(42.2 - 45.8)	
Parity				0.0012
1 st Born	3050	37.1	(35.1 - 39.2)	
2 nd or Higher	3722	32.6	(30.9 - 34.4)	
WIC Participation				<0.0001
Yes	3075	23.3	(21.5 - 25.1)	
No	3768	43.8	(41.9 - 45.7)	
Pregnancy Intendedness				<0.0001
Intended	4256	44.5	(42.7 - 46.2)	
Unintended	2582	19.4	(17.7 - 21.3)	

Data Source: Rhode Island Pregnancy Risk Assessment Monitoring System, 2004-2008.

¹ Sample size in each category; unknown and missing categories were excluded.

² 95% Confidence Interval.

The 2002-2009 PRAMS data were analyzed to assess the trends of daily multivitamin use in Rhode Island and the 2004-2008 aggregated data were analyzed to identify disparities among subgroups.

Multivitamin use prior to pregnancy was assessed using a survey question, "During the month before you got pregnant with your new baby, how many times a week did you take a multivitamin or a prenatal vitamin? These are pills that contain many different vitamins and minerals." The response categories included were 1) I didn't take a multivitamin or a prenatal vitamin at all, 2) one to three times a week, 3) four to six times a week, and 4) every day of the week. To identify disparities among subpopulations, the proportion of women who used a daily multivitamin was examined by selected characteristics, such as

maternal age, ethnicity, race, education, annual household income, marital status, health insurance type before pregnancy, parity, WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children) participation status, and pregnancy intendedness.

Data analyses were performed using survey data analysis (SUDAAN) software, which accounts for the complex sample design of the survey. The trend was examined using logistic regression analysis with linear trend test and the disparities among subgroups were examined using the chi-square tests. All unknown and missing responses were excluded from the analysis.

RESULTS

Trends in Daily Use of Multivitamin prior to Pregnancy

Between 2002 and 2009, the proportion of Rhode Island women who reported daily use of multivitamins prior to pregnancy fluctuated somewhat, ranging from 32.0% (95% CI: 29.1%-35.0%) to 36.7% (95% CI: 33.9%-39.7%). However, a statistical test for linear trends revealed that the proportion did not significantly improve during those periods ($p = 0.8672$). (Figure 1) Rhode Island's rates for daily use of multivitamins prior to pregnancy fell far below the Healthy People 2010 objective of 80%.

Prevalence of Multivitamin Use prior to Pregnancy

Among Rhode Island women with a live birth during 2004-2008, 51.8% (95% Confidence Interval: 50.4%-53.2%) reported not taking a multivitamin at all prior to conception, 7.1% (95% CI: 6.4%-7.8%) reported taking one to three times per week, and 6.4%

(95% CI: 5.7%-7.7%) taking four to six times per week. About one third of Rhode Island recent mothers (34.7%, 95% CI: 33.4%-36.1%) reported taking a multivitamin daily as recommended by the PHS and CDC. (Figure 2)

Daily Multivitamin Use by Selected Characteristics

The 2004-2008 aggregated data shows that the percentage of women who took a daily multivitamin prior to pregnancy varied significantly by socio-demographic characteristics. Mothers who were older than 30 years (46.2%), Non-Hispanic (36.3%), White (36.1%), Asian or Pacific Islander (37.6%), married (44.0%), and non-WIC participants (43.8%) were more likely to report daily use of multivitamins, compared to their counterparts. Mothers who had more than a high school

education (44.5%), annual household incomes greater than \$50,000 (50.5%), private health insurance (44.0%), a first born child (37.1%), and an intended pregnancy (44.5%) were also more likely to report daily use of multivitamins, compared to their counterparts. (Table 1)

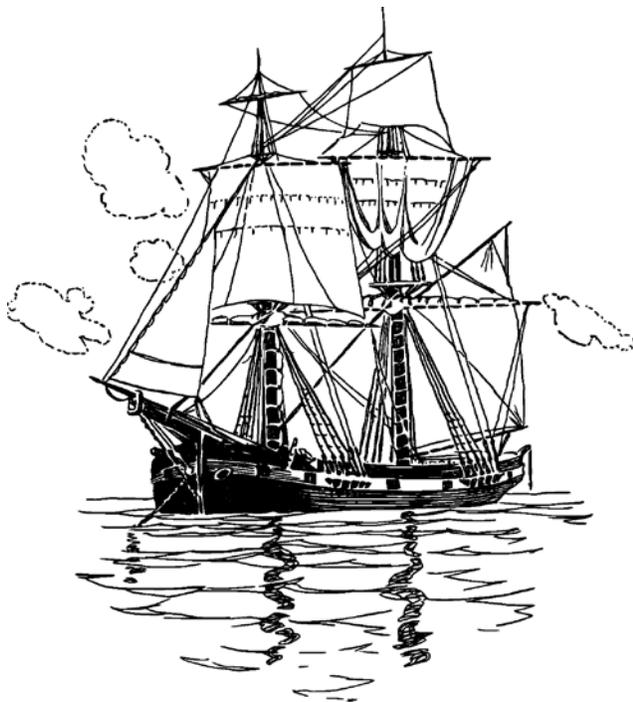
DISCUSSION

The findings of this report clearly demonstrates that the majority of women in Rhode Island do not take a daily multivitamin prior to pregnancy, no progress was made during 2002-2009, and there are considerable disparities among subpopulations in multivitamin use.

Because NTDs occur within the first month after conception, before most women are aware of their pregnancy, and because nearly 40% of pregnancies in Rhode Island are unplanned, it is important for all women of childbearing age to get enough folic acid, not just those who are planning to become pregnant.³

The Rhode Island Department of Health's Birth Defects Program is working with maternal and child health programs to educate women of reproductive age and health care providers about the importance of folic acid and multivitamin use. Specifically, the Birth Defects Program, with funding from the CDC, has purchased multivitamins for distribution to uninsured women who receive negative pregnancy tests at Title X funded family planning clinics. Additionally, the Program is working with the New England Birth Defects Consortium to distribute multivitamins to WIC participants at selected clinics in Rhode Island.

Health care providers can play a critical role in educating women of childbearing age about the importance of adequate folic acid consumption to reduce the risk of NTDs. They can incorporate information about folic acid into their helath encounters with women of childbearing age.



REFERENCES

1. Centers for Disease Control and Prevention. Spina bifida and anencephaly before and after folic acid mandate—United States, 1995–1996 and 1999–2000. *MMWR*. 2004;53(17):362–365.
2. Centers for Disease Control and Prevention. 2002 PRAMS Surveillance Report: Multistate exhibits multivitamin use. Available at: <http://www.cdc.gov/PRAMS/2002PRAMSSurvReport/MultiStateExhibits/Multistates2.htm>.
3. Centers for Disease Control and Prevention. Recommendation for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects. *MMWR Recommendations and Reports*. 1992;41(RR-14):1-7.
4. Centers for Disease Control and Prevention (CDC), Pregnancy Risk Assessment Monitoring System (PRAMS). Available at <http://www.cdc.gov/prams>.

Hyun (Hanna) Kim, PhD is Senior Public Health Epidemiologist in the Center for Health Data and Analysis, Rhode Island Department of Health, and Clinical Assistant Professor in the Department of Community Health, The Warren Alpert Medical School of Brown University.

Rachel Cain, BA is the PRAMS Program Coordinator in the Center for Health Data and Analysis, Rhode Island Department of Health.

Samara Viner-Brown, MS is Chief of the Center for Health Data and Analysis and Director of the Birth Defects Program at the Rhode Island Department of Health.

Mei-Fen Yang is a MPH candidate in the public health program at The Warren Alpert Medical School of Brown University.

Disclosure of Financial Interests

The authors and/or their significant others have no financial interests to disclose.

CORRESPONDENCE

Hyun (Hanna) Kim, PhD
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908-5097
e-mail: hanna.kim@health.ri.gov



Physician's Lexicon

An Epidemic of Words

THE GREEK ROOT, DEMOS, (MEANING A DISTRICT or territory but when incorporated into English words meaning 'of the people'), has given rise to a number of current terms including democracy, endemic, epidemic, pandemic, epidemiology, demography, demagogue and even the formal names, Democritus and Damocles.

Endemic defines those disorders (tacitly communicable) prevailing within the people but typically diseases of low intensity; epidemic, literally upon the people, refers to diseases generally of high affliction rates; and pandemic, disorders of global distribution, (ie, involving all of the people).

The secular, popular form of ancient Greek writing is often referred to as the demotic script as distinguished from the pictorial script used for royal and religious messages, a script called hieratic.

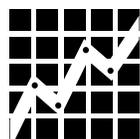
The English language is rich with words, beginning with *demo-* which are etymologically unrelated to those terms originally stemming from the Greek, *demos*. Demolish, for example, is derived from the Latin, *moliri*, meaning to construct or gather, and the Latin prefix, *de-*, meaning down or away from. The English word, demonstrate, is from the Latin, *demonstrare*, meaning to point out or display and also from the Latin prefix, *de-* (see above.) And, of course, there are a cluster of English words also employing the Latin prefix, *de-*; words such as demoralize, dementia, demeanor and demobilize.

The word, demon, is from the Latin, *daemon*, which in turn is derived from a Greek word originally defining someone who distributes something tangible (ultimately, portioning out men's destinies)

and thus becomes the name for a remorseless god. The word, pandemonium, meaning a chaotic, tumultuous state, descends from the same Greek root. John Milton (1608 – 1684), the English poet, invented the word to provide a title to the capitol of Hell.

And of course there is the word, demoiselle, from contemporary French, meaning a young maiden but ultimately from the Latin, *domina*, meaning mistress or lady of the household; and earlier from the Latin, *domus*, meaning household (as in words such as domicile, major domo, dome and even Don.).

– STANLEY M. ARONSON, MD



RHODE ISLAND DEPARTMENT OF HEALTH
MICHAEL FINE, MD
DIRECTOR OF HEALTH

VITAL STATISTICS

EDITED BY COLLEEN FONTANA, STATE REGISTRAR

Rhode Island Monthly Vital Statistics Report Provisional Occurrence Data from the Division of Vital Records

Underlying Cause of Death	Reporting Period			
	September 2010	12 Months Ending with September 2010		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	171	2,245	213.2	3,059.0
Malignant Neoplasms	175	2,282	216.7	6,311.5
Cerebrovascular Diseases	45	472	44.8	617.5
Injuries (Accidents/Suicide/Homicide)	50	615	58.4	10,154.5
COPD	37	488	46.3	547.5

Vital Events	Reporting Period		
	March 2011	12 Months Ending with March 2011	
	Number	Number	Rates
Live Births	975	11,754	11.2*
Deaths	932	10,006	9.5*
Infant Deaths	(9)	(67)	5.7#
Neonatal Deaths	(8)	(66)	5.6#
Marriages	245	6,074	5.8*
Divorces	351	3,277	3.1*
Induced Terminations	330	4,145	352.6#
Spontaneous Fetal Deaths	51	665	56.6#
Under 20 weeks gestation	(42)	(593)	59.3#
20+ weeks gestation	(9)	(70)	6.0#

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

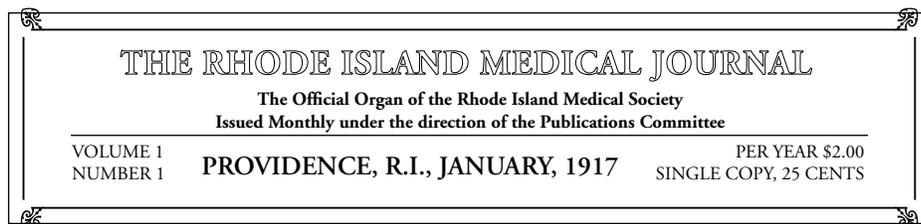
(b) Rates per 100,000 estimated population of 1,053,209. (www.census.gov)

(c) Years of Potential Life Lost (YPLL).

Note: Totals represent vital events that occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.

* Rates per 1,000 estimated population

Rates per 1,000 live births



NINETY YEARS AGO, SEPTEMBER, 1921

W. Louis Chapman, MD, discusses sialolithiasis, or calculi in the salivary glands or their ducts. The submaxillary gland or ducts appear to be the most frequent site for stones to form, and these are composed of phosphate and carbonate of calcium in varying proportions. The origin of accretion may be either organic in the form of bacterial masses, or inorganic such as “particles of oyster shell which some writers think may enter the duct orifice.” The primary purpose is to recognize them, acknowledging that they may be the cause of parotid and submaxillary tumors, and dealing with them when found.

Ocular tuberculosis is examined and presented by J. W. Leech, MD of Providence. He focuses on the more frequent manifestation of the disease in the anterior segment and in the fundus. He notes the difficulty in distinguishing tuberculosis sclerokeratitis from more common interstitial keratitis of luetic origin in the early stages, but notes in the case of tuberculosis sclerokeratitis that ciliary redness is more accentuated at one point on the limbus, and that the corneal infiltrate is more limited to one part of the cornea. He discusses treatment with “the usual tonic and hygienic measures,” and describes a treatment he uses involving a dilution of Old Tuberculin.

It is noted that the June issue of the Medical Review of Reviews was “a special radium number dedicated to Mme. Curie.” The issue consists exclusively of articles about radium and its uses, and is available upon request to any physician interested in the uses of radium.

FIFTY YEARS AGO, AUGUST 1961

MHRI editor Seebert J. Goldowsky, MD, examines some of the pioneering work of Rhode Island surgeon and physician John W. Keefe, MD (1863-1935). In particular, he looks at his work in pyloric stenosis and reprints a case report by Dr. Keefe in which an infant, only a few weeks old, suffers from dramatic weight loss and an inability to keep down milk—either from the mother or modified—and in which, after a thorough examination, is operated upon, and healthy weight gain begins to occur.

Frank Glenn, MD, looks at the past and present of cardiovascular surgery, different types of cardiovascular disease, valvular disease, tumors, myocardial ischemia, occlusive disease, trauma, and congenital cardiac anomalies. He identifies as some more amenable to surgery than others, and divides them into two groups: congenital and acquired.

Richmond S. Paine, MD, discusses the early diagnosis of cerebral palsy. He makes mention of conventional methods of neurological examination for adults being adapted for infants, but notes that early diagnosis of cerebral palsies depends relatively little on traditional localizing neurological signs. The earliest signs to the existence of a congenitally abnormal brain usually appear at six to eight weeks of age, when responsive smiling to

the mother is probably the first sign of the emergence of cortical function. Delayed interest is often mistaken for blindness, but more often turns out to be a reflection of mental deficiency. Dr. Paine goes on to discuss other symptoms and signs at later months of development.

In “Progress Notes,” Garfield G. Duncan, MD, observes that progress in the treatment of diabetes has complicated rather than simplified. He cites a wide variety of diets, each with their own advocates, eight insulins and a variety of mixtures to choose from, and three oral preparations which may be used singly, combined, and with or without insulin. Dr. Duncan attempts to bring the control of diabetes back into reasonable and effective procedures that have survived the test of time with proven results. While partial treatment may be better than no treatment at all, it is still a far cry from control of one's diabetes which is, of course, the physician's goal.

The town of New Shoreham on Block Island is looking for a doctor for general practice—not currently having one. While Block Island does not have a hospital or medical clinic, they make note of a close relationship with nearby mainland hospitals, and the availability of immediate transport for patients if necessary.

TWENTY-FIVE YEARS AGO, AUGUST 1986

In an editorial, Seebert J. Goldowsky, MD, talks about long-term care, the issues surrounding it, the availability of qualified staff and facilities. Much of the problem, too, comes from who pays for it. Medicare does not cover most long-term care, and health insurance coverage can vary.

A look is taken at epidural analgesia in community hospitals by J. J. O'Neill, MD, R. T. O'Neill, MD, M. Schwartz, MD, and R. P. Curhan, MD. When administered by trained, competent staff, the method is considered safe and effective. While side effects such as hypotension may arise in regional analgesia, this can be combated by trained hands in intravenous infusions, leg elevation, nasal oxygen, and—in rare cases—25 to 50 mg of ephedrine.

Ian Rockett, MD, MPH and Sandra Putnam, MSc examine the connection between alcohol ingestion and unintentional nonvehicular injuries. It's noted that injuries are the fourth leading cause of death in the United States after heart disease, cancer, and cerebrovascular disease, but are the leading killer of Americans between the ages of one and 44. They discuss how to differentiate between intentional and nonintentional injury, types of injury, and measuring alcohol consumption. More study is needed, and more data is required, nonetheless, passive countermeasures can be taken in modifications to the environment rather than behavior. Examples given include fire-resistant fabrics, fences around swimming pools, smoke detectors, and so forth. Education, too, should be emphasized and kept ongoing.

The Name of Choice in MRI



'OASIS' 1.2 Tesla open-sided scanner

Open MRI of New England, Inc.

- High Field Open-Sided and Short-Bore Systems
- Fast appointments and reports
- Insurance authorization services, physician web portal and EMR system interfaces



ADVANCED Radiology, Inc.

- Low dose Multislice CT systems
- Digital xray, bone density and ultrasound
- Insurance authorization services, physician web portal and EMR system interfaces



Brightspeed low dose CT System

525 Broad St. • Cumberland
T 725-OPEN (6736) F 726-2536

1002 Waterman Ave • East Providence
T 431-5200 F 431-5205

148 West River St • Providence
T 621-5800 F 621-8300

501 Great Road • North Smithfield
T 766-3900 F 766-3906

335 Centerville Rd • Warwick
T 732-3205 F 732-3276

101 Airport Rd • Westerly
T 315-0095 F 315-0092



One stolen laptop —
2,000 exposed patient records.

Let us shield you.

Patient information can be lost or stolen in many ways. But when it happens, you're the one who must clean up the mess and incur the expense.

DataShield, a coverage enhancement from NORCAL Mutual, protects you from costs related to information and network security — at no additional cost to you. To purchase your NORCAL Mutual coverage call RIMS Insurance Brokerage at 401-272-1050.



To find out more visit nocalmutual.com/datashield

Proud to be endorsed by the Rhode Island Medical Society.



*Our passion protects
your practice*