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Corporate Wellness: Is It Healthy For Employers?

By Anne Ciesla Bancroft

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There are many benefits to having a healthier workforce. Healthy employees may be absent less, take fewer leaves of absence, be more productive, work longer, and have a better overall quality of life. In addition, employers may pay less for health insurance.

With these goals in mind, many employers are implementing corporate wellness initiatives. Effective corporate wellness programs identify and reduce risks and educate and motivate employees to improve individual health. Discounts or penalties on health care premiums, health exams and screenings, health coaches, energy management exercises, weight-loss and smoking cessation programs, and rewards such as gift cards or vacations are a few approaches used by employers.

Some employers go even further and implement outright restrictions on employment or health insurance based on weight, smoking, and even hazardous activities, such as skydiving.

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While the results may be beneficial to both employers or employees, the end won't necessarily justify the means. Unless implemented properly, efforts to improve employee health can face challenges from several fronts, including claims of invasion of privacy and unlawful discrimination.

It's None of Your Business

Many corporate wellness initiatives are about behavior that occurs outside of work.

Most workplaces are nonsmoking, but many employers don't want their employees to smoke at all.

Employers can offer only healthy food and snacks in the cafeteria, but that doesn't help if the employee eats junk and fast food the rest of the time. But employer attempts to regulate or prohibit such "outside" behavior and to monitor employee compliance can give rise to claims for invasion of privacy.

Privacy rights can be found in the federal or a state constitution; a federal or state statute; or under "common law."

Although not specifically mentioned, the right to privacy in the public sector is found in the search and seizure provisions of the Fourth Amendment to the U.S. Constitution.

Employees in the private sector may find a right of privacy in their state constitutions, and courts have held that such constitutional privacy protections can form the basis for a clear mandate of public policy supporting a wrongful discharge claim against a private employer.

Both "outside" activity restrictions and tests to monitor compliance, such as urine, blood or breathalyzer tests, could violate an employee's right to privacy.

One recent case filed in federal court in Massachusetts tests these theories. In Rodrigues v. EG Systems, Inc., d/b/a Scotts LawnService, Scott Rodrigues claimed that Scotts LawnService violated his common law right to privacy and civil rights by requiring him to take a urine test for the presence of nicotine and by terminating his employment because he failed it due to his off-duty and off-premises smoking.

Rodrigues further claimed that his discharge constituted a wrongful termination and discriminatory denial of benefits under the Employee Retirement Income Security Act (ERISA).

Notably, the complaint questions Scotts LawnService's prohibition on smoking but not other "unhealthy practices" such as "obesity, consumption of alcohol, failure to exercise, skydiving, excessive television viewing, eating processed sugar, owning dangerous pets, flying private aircraft, mountain climbing, downhill skiing, single-handed sailing, or spreading toxic chemicals on lawns."

"What's next?" is a question employers implementing workplace wellness programs can be expected to face.

HIPAA

Another potential source of privacy rights for employees is the Health Insurance Portability and Accountability Act (HIPAA), which protects the privacy of personal health information.

HIPAA nondiscrimination regulations regarding "bona fide wellness programs" require that wellness programs be designed to promote good health; allow for annual qualification; make awards available to all similarly-situated individuals; and provide a reasonable alternative, and notice thereof, to employees unable to

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comply with program requirements due to a medical condition.

Under the recently promulgated regulations, the value of rewards (such as discounts, contribution rebates, or waiver of cost-sharing requirements) for the wellness program is limited to 20 percent of the unsubsidized cost of employee-only coverage under the health insurance plan.

Compliance with HIPAA, however, does not mean a program will survive challenges on other grounds, such as discrimination.

Why Me?

Some employees may feel harassed or discriminated against when faced with healthy workplace initiatives.

Employees may claim that they are treated differently because of their protected status (disparate treatment), or that their employer's policy or practice adversely impacts a protected group (disparate impact).

Accordingly, wellness program participation, use and confidentiality of employee health information, and screening must be consistent with federal, state, and local anti-discrimination laws.

The Americans with Disabilities Act (ADA), for example, prohibits discrimination against a qualified individual with a disability who can perform the essential functions of the job with or without reasonable accommodation. A disability is defined as a physical or mental impairment that substantially limits a major life activity.

Employees also are protected from discrimination if they are "regarded as" having or "have a record" of a disability – even if they are not currently disabled – and if they associate with a disabled person. Employers should avoid making assumptions about employee health based on appearance, age, or any other criteria.

In addition, under the ADA, employers have an obligation to provide a reasonable accommodation to a disabled employee who can perform the essential functions of the job. This obligation would apply to an employee's participation in a corporate wellness program.

The Equal Employment Opportunity Commission (EEOC) has indicated, with qualifications, that voluntary wellness programs do not violate the ADA. Penalizing employees for not participating, such as through higher insurance premiums, can render a program involuntary, however.

In addition, the ADA limits the use of medical examinations and inquiries in hiring and employment. Generally, employers are not permitted to make disability-related inquiries or to conduct medical examinations unless job-related and consistent with business necessity.

Many wellness initiatives use Health Risk Assessments (HRAs) to obtain employee health information. The EEOC has indicated that HRAs are permissible where they are part of a voluntary wellness program – but may be discriminatory if completion is required in order to participate in the program.

However, behavioral questions regarding eating, sleeping, exercise, and other habits may fall outside the scope of ADA restrictions. Health information obtained from HRAs must be kept confidential.

Some state or local anti-discrimination laws also prohibit discrimination on the basis of "disability" and/or "handicap," and may define those conditions more broadly than a "disability" under the ADA.

Weight is an area of focus for many wellness programs. Obesity, usually where morbid or caused by another medical condition, may be a disability under ADA or state law if it meets the statutory definition, and some local ordinances specifically prohibit discrimination on the basis of weight.

Corporate wellness programs also could be subject to challenge on the basis of other protected classifications, such as race, national origin, gender, and age, if employers screen or penalize employees for conditions more prevalent among those protected groups.

Certain health conditions may be exhibited more frequently in older workers or employees of a particular race or national origin.

Some states also prohibit discrimination on the basis of atypical cellular or blood trait or genetic information, which could also constitute a basis for challenging corporate wellness initiatives such as health screenings.

Many states, including New York, New Jersey, and Colorado, also restrict employers from engaging in "lifestyle discrimination" which can range from discrimination against smokers to discrimination based on any lawful activity off employer premises during working hours. Employers attempting to regulate out-of-work activity may run afoul of these laws.

Employers who use physical characteristics in employment decisions, such as hiring, could be subject to claims for discrimination. Employers should avoid disability-related inquiries; health or physical-related criteria; restrictions on personal activities; and physical or medical testing unless work-related and applied consistently across employees in a job category and not just to members of one protected class.

Health Insurance Audits

While there are many benefits to improving employee health, reducing the cost of health insurance is a primary consideration. Some employers impose surcharges or higher premiums on employees who do not meet the company wellness thresholds or who refuse to participate in wellness initiatives.

But there are other alternatives that can significantly reduce costs without employer involvement in employee health.

For example, audits of health plans to determine whether enrolled employees and dependents are eligible – such as confirming current employment, marital, domestic partner or civil union status, and dependant age and relationship – can significantly reduce costs.

Higher deductibles and health savings accounts (HSAs) can make employees more financially responsible, and thus provide incentives for employees to improve their own health.

What Can Employers Do?

More and more employers are beginning to

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take aggressive steps to improve the health of their employees, and are benefiting from the results. Companies interested in implementing wellness programs should keep the following guidelines in mind:

Maintain safe and healthy work environments:

- use a third party to implement corporate wellness programs
- use voluntary programs, such as employer-paid physicals, on-site exercise facilities and personal trainers, wellness reimbursements, smoking cessation and weight-loss programs, health coaches, and healthy food options in the cafeteria/vending machines

Audit health plan participation:

- aggregate data and trends
- maintain confidentiality of individual health information

Incentivize, don't penalize:

- focus on education
- corporate wellness and employment decisions need to be separate
- train employees who implement corporate wellness programs to comply with the law and company policy

Properly implemented wellness programs that are voluntary; motivate through incentives rather than penalties; use health information in a permissible way; maintain confidentiality of health information; operate at arm's-length from hiring and employment decisions; and focus on education and behavior can achieve the goals of a healthier and more productive workforce and lower health insurance costs without subjecting employers to liability.

Making The Adjustment To Medicare Administrative Contractors (MAC)

By Anne E. Jorgensen

This article was first published in BC Advantage.

After years without change, the Medicare billing contractor system is getting a facelift. For the first time, Medicare Part A and Medicare Part B will be administered by one entity rather than the traditional fiscal intermediaries and carriers that have administered the programs to both beneficiaries and providers. The big question is, how will this affect providers?

In December of 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 was passed by Congress and signed into law by President Bush. While this legislation is best known for bringing us the Medicare Part D Prescription Drug Benefit, Section 911 of the MMA required the Centers for Medicare and Medicaid Services (CMS) to replace the current fiscal intermediary and carrier contracts for the administration of Medicare benefits with new contracts with Medicare Administrative Contractors (MACs). This change is commonly referred to as the Medicare Contracting Reform. CMS issued a final rule with regard to this reform on November 26, 2006, in which it explained that the reform "is intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and per formance incentives."

As of November 1, 2006, 20 fiscal inter mediaries and 18 carriers were administering Medicare under contracts that generally renewed automatically from year to year. The award of Medicare contracts was not competitive, as provider institutions were responsible for nominating fiscal intermediaries to process Part A claims and the Secretary of Health and Human Services was required to choose Part B carries from a small pool of private companies. The workload was not equally distributed as the largest fiscal intermediary processed more claims than the 17 smallest fiscal intermediaries combined. Furthermore, CMS lacked an effective method for the termination of these contracts. In short, CMS lacked significant control over the administration of Medicare Part A and Part B, and the system lacked the ability to change and adapt as the world of health care delivery developed.

Organization of the New Medicare Contracting System

To remedy the basic flaws in the Part A and Part B Medicare administrative system and to comply with Section 911 of the MMA, CMS developed the Medicare Administrative Contractor contracting system. In this system, the country will be divided in to fifteen "A/B Jurisdictions" and each A/B Jurisdiction will be assigned to one MAC, who will administer both Part A and Part B claims. These A/B Jurisdictions were assigned based upon three primary purposes: (1) to promote competition; (2) to balance the allocation of workloads; and (3) to account for integration of claims processing activities. The A/B Jurisdictions are as follows:

1	American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands
2	Alaska, Idaho, Oregon, Washington
3	Arizona, Montana, North Dakota, South Dakota, Utah, Wyoming
4	Colorado, New Mexico, Oklahoma, Texas
5	Iowa, Kansas, Missouri, Nebraska
6	Illinois, Minnesota, Wisconsin
7	Arkansas, Louisiana, Mississippi
8	Indiana, Michigan
9	Florida, Puerto Rico, U.S. Virgin Islands
10	Alabama, Georgia, Tennessee
11	North Carolina, South Carolina, Virginia, West Virginia
12	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
13	Connecticut, New York
14	Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
15	Kentucky, Ohio

The first MAC was awarded in the summer of 2006 to Noridian Administrative Services for A/B Jurisdiction 3. Trailblazer Health Enterprises was announced as A/B Jurisdiction 4's MAC shortly thereafter. Since then, it has been determined that Wisconsin Physicians Service Insurance Corporation is the Jurisdiction 5 MAC, Palmetto GBA is the Jurisdiction 1 MAC, and Highmark Medicare Services is the Jurisdiction 12 MAC. All contracts are expected to be awarded by September of 2008 with implementations occurring by July of 2009.

The original design of the Medicare Contracting Reform called for the award of eight additional MAC contracts: four for durable medical equipment (DME) services and four for home health and hospice care (HHHC). Ultimately, CMS decided to award only four additional MAC contracts. The A/B Jurisdictions were combined to form the four DME Jurisdictions, each with its own MAC. HHHC claims and services will be grouped by DME Jurisdiction, but administered in one particular A/B Jurisdiction within that DME Jurisdiction. Each DME MAC has already been awarded as follows with the A/B Jurisdictions served noted in parentheses:

DME Jurisdiction	A/B Jurisdictions Included	MAC	HHHC Administrator
A	12, 13, 14	National Heritage Ins. Co	Jurisdiction 14
B	6, 8,15	AdminiStar Federal Inc.	Jurisdiction 15
C	4, 7, 9, 10, 11	CIGNA Government Services	Jurisdiction 11
D	1, 2, 3, 5	Noridian Administrative Services	Jurisdiction 6

CMS anticipates that the new Medicare Contracting Reform will be fully implemented and operational by 2011. The transition period has already begun for those MAC contracts already awarded.

What Do These Changes Mean?

Medicare Fee-for-Service Claims represent over 80 percent of all claims for Medicare services. The Medicare Contracting Reform focuses on the administration of these Fee-for-Services Claims. The duties of the selected MACs, the administrators, includes not only claims processing but also customer service, provider education, financial management, payment safeguards, and information systems security. In expanding the service requirements for the MACs, CMS is directly affecting the Medicare benefits for both the providers and the beneficiaries.

For beneficiaries and providers alike, the consolidation of Part A and Part B claims processing will provide a single point of contact. CMS anticipates that customer service will improve. Gone will be the days of calling one number for Part A and one number for Part B as related to the same hospital stay. All beneficiary calls will be fielded through the 1-800-MEDICARE number and directed accordingly. Likewise, providers who provide services in a Part A location and a Part B location, such as a hospital stay followed by rehabilitation, will ideally be able to have their questions regarding claims processing answered in one location. Furthermore, full and open competition for MAC contracts along with performance reviews by CMS, service reviews from providers, and limited contract terms of only five years will encourage contractors to deliver better service to providers.

The reform also requires the MAC to focus on providing physician practices and all health care providers with improved training on Medicare rules and correct claims submission. The emphasis on education is designed to help ensure that physicians and providers are better able to meet challenges and changes in the Medicare program. While this plan may ultimately work, CMS is likely overlooking the growing pains of such a global change.

Currently, the Part A and Part B claims processing is split between different entities that do not communicate with each other. As a result, the fiscal intermediaries and the carriers do not compare the Part A and Part B claims submitted for patients, even if those claims relate to a coordinated treatment effort. With one MAC administering both Part A and Part B, that MAC will now be able to compare the Part A and Part B claims submitted. While this comparison is good for the Medicare system, it could present problems for the providers.

As improper coding and claims are more readily identified and computerized medical reviews are used to automatically examine, compare, and flag questionable claims prior to payment, claims that would have been paid immediately as a "clean claim," may be delayed, denied, or reduced if the corresponding Part A or Part B claim submitted from another provider does not match. Part of the duties of the MAC will be to reconcile such claims for coordinated health care when such discrepancies exist. The MAC will be tasked with determining the reimbursement for the providers. As a result, providers may face decreased reimbursement or even denied claims through no fault of their own.

To illustrate the above, consider the following scenario: Part A and Part B providers coordinate the care of Patient X, who had surgery. The Part A provider correctly coded and billed the inpatient stay for Patient X, but the Part B provider incorrectly coded and billed the professional services for the surgery and related care. Once submitted, the MAC identifies the inconsistency between the Part A and Part B coding and claims. Not knowing which claim was improperly submitted, the MAC delays payment on both Part A and Part B claims as it reconciles the submissions. Ultimately, the MAC reduces the payment for each claim based on its review. Through no fault of its own, the Part A provider was

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not fairly compensated for the services provided.

As they navigate this new Medicare system, Part A and Part B providers must recognize the potential need to work together towards the same goal: fair and equitable reimbursement for services. To combat the potential problems with irreconcilable claims, Part A and Part B providers may need to educate themselves on not only their own billing policies and procedures but also the billing policies and procedures of those with whom they coordinate patient care. If possible, Part A and Part B providers may want to consider working together with regard to billing. In particular, Part A providers should consider how their billing and coding processes relate to the billing and coding for outpatient programs and departments, inpatient services such as radiology, pathology, and anesthesiology, and other programs that combine Part A and Part B services. Regardless of the means, whether it be combined billing, education, or another method, communication between the providers will be necessary to eliminate discrepancies in billing and allow each provider to be correctly and adequately reimbursed for those services provided.

The new Medicare Contracting Reform will completely re-vamp the Medicare process. As reimbursements levels decrease and the number of Medicare beneficiaries increase, health care providers may begin to see an impact on the bottom line. As a result, any additional reductions in collections due to increased scrutiny of claims and constantly changing rules could be difficult for health care providers to weather. However, education and communication will aid both Part A and Part B providers as they navigate this new system.

State And Federal False Claims Acts

By Patricia Barron

The Federal False Claims Act (Federal FCA) was enacted in 1863 during the presidency of Abraham Lincoln and at the height of the Civil War. Deceptive military contractors were defrauding the Union Army out of hundreds of thousands of dollars by supplying troops with defective products and faulty equipment. In response, the Federal FCA was established in an effort to prevent such fraudulent acts against the government. Under the Federal FCA's original provisions, a private citizen was able to file a civil action, also known as a "qui tam" action, on behalf of the government, against persons engaged in fraudulent acts. As an added incentive, these qui tam plaintiffs were also entitled to share in any money the government eventually recovered.

Since then, the Federal FCA has changed significantly, but its ultimate goal is still the same – to prevent fraud against the government. Today, the Federal FCA imposes civil liability against any person or entity that knowingly submits, or causes the submission of, a false or fraudulent claim for payment to any federally funded program. A person or entity that is found liable under the Federal FCA is subject to a civil penalty between $5,500 and $11,000 plus three times the amount of damages sustained because of the fraudulent act, plus the costs of any civil action brought to recover such penalties or damages. The Federal FCA still allows qui tam actions, which allow a private citizen – now also known as a "whistleblower" or a "relator" – to file an action on behalf of the government against persons engaged in fraud and to share in any recovered funds.

The focus of the Federal FCA has also changed through the years. While the Federal FCA generally applies to any false claim submitted for payment to any federally funded program, recently it has been primarily used as a tool for combating health care fraud and abuse, most notably, Medicare and Medicaid billing fraud. The health care industry now consistently accounts for the vast majority of settlements and judgments obtained by the federal government under the Federal FCA. The Centers for Medicare and Medicaid Services (CMS) recognizes that the best way to cut Medicare and Medicaid spending and maintain the integrity of the programs is to actively enforce anti-fraud compliance laws, like the Federal FCA, to reduce Medicare and Medicaid fraud and abuse.

To further combat health care fraud and abuse, Congress enacted the Deficit Reduction Act of 2005 (DRA). The DRA contains, among other things, provisions to slow spending in Medicare and Medicaid and creates financial incentives for states to enact anti-fraud legislation. Section 6031 of the DRA, which became effective January 1, 2007, encourages states to enact their own false claim act (State FCA) to establish liability for the submission of false or fraudulent claims to state Medicaid programs. Those states that enact a qualifying State FCA will receive an additional 10 percent of the damages recovered in Medicaid fraud cases. For example, typical recoveries of damages that are shared with a state are in direct proportion to the state's share of the costs to its Medicaid program. Thus, if a state's share of the costs to its Medicaid program is 40 percent, then the state would be entitled to receive 40 percent of the damages recovered. But under the DRA's new incentive program, if the state has a qualifying State FCA, that state would now be entitled to receive 50 percent of the damages recovered.

In order for a state to qualify for this incentive, the State FCA must meet certain requirements, as determined by the Office of the Inspector General (the OIG) of the Department of Health and Human Services. First, the State FCA must establish liability to the state for false or fraudulent claims, as described in the Federal FCA, with respect to any expenditures related to the state Medicaid plan. Second, the State FCA must contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the Federal FCA. Third,

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the State FCA must contain a requirement for filing an action under seal for 60 days with review by the State Attorney General. Finally, the State FCA must contain a civil penalty that is not less than the amount of the civil penalty authorized under the Federal FCA.

On January 7, 2008, New Jersey's Assembly unanimously passed a State FCA, which was then signed into law by Governor Jon Corzine on January 14, 2008. New Jersey's FCA is based upon the Federal FCA and similarly imposes civil liability against any person or entity that knowingly submits, or causes the submission of, a false or fraudulent claim for payment to any state funded program. It also provides financial incentives to whistleblowers and relators to expose fraud affecting state funds, much like the Federal FCA.

The enactment of New Jersey's FCA follows the trend of new State FCAs as it joins 22 other states – Arkansas, California, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Oklahoma, Rhode Island, Tennessee, Texas, and Virginia – as well as the District of Columbia, that have enacted their own State FCA.

Just as the Federal FCA is not limited to health care fraud, the majority of State FCAs protect the state's funds generally, rather than protecting only state Medicaid funds. In fact, only seven of the 23 states have State FCAs that apply only to fraud involving Medicaid or other state health care funds: Arkansas, Georgia, Louisiana, Michigan, Missouri, New Hampshire, and Texas. The remaining states and the District of Columbia have State FCAs that apply to fraud involving a broad range of state-funded programs.

While most of the State FCAs are based upon the Federal FCA, there are some differences. For example, in Arkansas and Missouri, a whistleblower or a relator may receive a reward for providing information that leads to the recovery of state funds, but these states do not allow private citizens to file qui tam actions. Additionally, several states – Hawaii, Massachusetts, Nevada, and Tennessee – have expanded on the Federal FCA's commonly-used theories of liability and create a new legal theory for holding liable a person or entity who is the "beneficiary" of the "inadvertent submission" of a false or fraudulent claim, if that person or entity fails to disclose (and presumably correct) the false claim after discovering it. Tennessee's FCA also reaches beyond false or fraudulent "claims" and imposes liability for false or fraudulent "conduct" that apparently does not necessarily involve "claims" submitted to the state and adds a new category of liability for "any false or fraudulent conduct, representation, or practice in order to procure anything of value directly or indirectly from the state or any political subdivision."

With the ever-expanding field of anti-fraud legislation targeted to health care fraud and abuse, it is more important than ever to ensure compliance in medical practices. By way of example, the following list includes examples of the various types of health care/medical fraud:

- "phantom billing" or billing for tests not performed
- performing inappropriate or unnecessary procedures
- charging for equipment and/or supplies never ordered or used
- billing Medicare or Medicaid for new and expensive equipment but providing the patient with used and cheap equipment
- "reflex testing" or automatically running a test whenever the results of some other test fall within a certain range, even though the reflex test was not requested by a physician
- "defective testing" or when a test or part of a test was not performed because of technical trouble (i.e. insufficient or destroyed sample, machine malfunction) but is billed for anyway
- "unbundling" or using two or more Current Procedural Terminology (CPT) billing codes instead of one inclusive code for a defined panel where rules and regulations require "bundling" of such claims
- submitting multiple bills, in order to obtain a higher reimbursement for tests and services that were performed within a specified time period and which should have been submitted as a single bill
- "double billing" or charging more than once for the same service (i.e. billing using an individual code and again as part of an automated or bundled set of tests)
- "up coding" or inflating bills by using diagnosis billing codes that indicate the patient experienced medical complications and/or needed more expensive treatments (i.e. billing for complex services when only simple services were performed, billing for brand-named drugs when generic drugs were provided, listing treatment as having been for a more complicated diagnosis than was actually the case)
- routinely waiving patient co-payments

If you have any questions or concerns please feel free to contact the author at 609.895.6737 or pbarron@foxrothschild.com, or any other member of the Health Law Group.

Rehabilitating Impaired Physicians in Pennsylvania

By William H. Maruca, Esquire

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Grammy-winning singer Amy Winehouse rose up the pop charts last year by singing "They tried to make me go to rehab, I said no, no, no," then went to rehab anyway, leaving a trail of tabloid headlines in her wake. With a lot less fanfare, many physicians have been confronting and conquering their own drug and alcohol issues quietly through impaired physicians programs while keeping their licenses and preserving their careers.

The Associated Press reported in December 2007 that as many as 8,000 doctors may be in state-approved confidential drug and

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alcohol rehabilitation programs that let doctors continue practicing during their recovery, subject to oversight and monitoring. The Federation of State Physician Health Programs estimates the number at 9,000. These programs strive to promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians before their illness impacts the care rendered to patients. While chemical dependency was historically the focus of these programs, they have expanded to include mental health and behavioral health problems, stress management, physical illnesses, cognitive deficits, and "disruptive physician" conduct.

Impaired physician programs made news last year when California voted to abolish its program effective June 30, 2008, under pressure from the San Diego Center for Public Interest Law and other consumer watchdogs after the fifth in a series of audits reported significant deficiencies in monitoring and enforcement. California physicians are waiting to see if a new program will be adopted to replace it before it sunsets later this year.

Pennsylvania's Physicians' Health Programs (PHP) has been in operation since 1970, and its Professional Health Monitoring Program (PHMP) since 1986. These programs are often confused with each other but are fundamentally distinct.

Physicians Health Programs

The PHP is operated by the Foundation of the PA Medical Society under a Memorandum of Understanding with the State Board of Medicine. The PHP monitors professionals with chemical dependency; mental health issues; behavioral health problems; physical illnesses; stress management; cognitive deficits, and disruptive behavior. Its services are available to allopathic and osteopathic physicians, residents, medical students, physician assistants, dentists, dental hygienists, and podiatrists.

Participants enter into a contract with the PHP which typically lasts five years for chemical dependency matters. Random urine drug screen is required with declining frequency beginning at 50-60 times per year in the first year reduced to 10-20 times in the final year. Members are required to attend 12-step support (self help) group meetings (AA, NA, Caduceus) 3-4 times per week in the first three years, 2-3 times per week in the last two years. Group and/or individual therapy or treatment is required for a minimum of two years. Workplace/practice monitoring is required.

The PHP also offers mental health monitoring services, with three year contracts and support (self help) group requirements as recommended by the treating professional and individual or group therapy or treatment for the entire contract period as indicated. For physicians with cognitive deficits, PHP facilitates re-entry by following progress and monitoring work through clinical review by volunteer physicians. PHP also monitors physicians who have been identified as "disruptive," typically requiring evaluation and treatment by qualified psychiatrists to address anger management and appropriate workplace conduct. In recent years many hospitals have adopted disruptive physician policies and will invoke them to require physicians to seek help when their verbally abusive or uncooperative behavior threatens to impair patient care. This approach is not without controversy - some physicians feel they have been wrongly labeled "disruptive" without justification or in retaliation for raising quality concerns or other valid issues.

The PHP's program is confidential, but participation must be disclosed to the physician's employer and the medical staff office of facilities where the physician practices. Generally the employer and hospital are sent a periodic letter confirming that the physician remains in compliance with the program's requirements without further details.

Professional Health Monitoring Programs

The Professional Health Monitoring Programs (PHMP) of the state Bureau of Professional & Occupational Affairs (BPOA) is a state run program, as contrasted with the PMS Foundation's private program. The PHMP provides a method by which professionals suffering from a physical or mental impairment, such as chemical dependency, may be directed to appropriate treatment and receive monitoring to ensure that they can safely practice their licensed profession. The PHMP includes two separate programs, the Voluntary Recovery Program (VRP) and the Disciplinary Monitoring Unit (DMU).

The Voluntary Recovery Program offers confidential, voluntary treatment and monitoring of licensed professionals suffering from mental or physical impairments. The Disciplinary Monitoring Unit manages the cases of impaired licensed professionals under formal discipline by the various boards and commissions.

The PHMP requires participants to submit to random toxicology screenings; abstain from the use of prohibited substances; comply with the recommendations made by their PHMP-approved treatment provider(s); submit to monitoring of their practice by a workplace monitor; actively attend support group meetings as recommended by the PHMP-approved treatment provider and approved by the PHMP; and abide by all other terms and conditions of the program and the applicable licensing board's consent agreement or board order.

The VRP requires a practitioner to enter into a consent agreement with their licensing board for a period of a minimum of three years. The consent agreement stipulates that disciplinary action, including suspension or revocation, will be deferred so long as the licensee adheres to the terms and conditions of the agreement and maintains satisfactory progress in the program. Upon successful completion of the VRP program, no disclosure, publication or public record is made of the participant's involvement in the VRP or the events precipitating their enrollment.

Licensees wishing to participate in the Voluntary Recovery Program (VRP) must:

- agree to be assessed by a VRP-approved assessor and adhere to the treatment plan recommended by the evaluator
- comply with all of the terms and conditions for VRP participation
- enter into an agreement with the licensing board stipulating that disciplinary action, including suspension or revocation, will be deferred so long as the licensee adheres to the agreement

Currently ineligible for the VRP are:

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- licensees convicted of, or pleading guilty, or no contest to a felony or misdemeanor under the Controlled Substance, Drug, Device and Cosmetic Act (this can be a major barrier if the physician has been caught diverting prescription medications or has self-disclosed such activities to the authorities and agreed to a plea bargain)
- licensees with a history of practice problems clearly involving significant patient harm
- licensees who have been involved in the diversion of controlled substances for the primary purpose of sale or distribution
- licensees who have committed sexual boundary violations
- licensees who have failed to successfully complete a similar program in another jurisdiction

The VRP is currently available to Pennsylvania chiropractors; dentists, allopathic and osteopathic physicians, registered nurses, optometrists, pharmacists, physical therapists, podiatrists, licensed social workers, psychologists, marriage and family therapists and professional counselors, speech-language therapists and veterinarians.

ADA Issues

The Americans with Disabilities Act (ADA) may offer some protection to physicians in recovery. A person who is not currently dependent on alcohol or engaging in the illegal use of drugs but who has a history of past drug addiction or alcoholism can qualify as an individual with a disability under the ADA if the past addiction substantially limited a major life activity, or is regarded as substantially limiting. An employer may not discriminate against, and may need to accommodate, a qualified applicant or employee with a past chemical dependency who can competently perform the job and comply with uniformly-applied employer conduct rules.

Get Help Before You Get Help

Practitioners who are struggling to conquer substance abuse problems should consult with experienced counsel before contacting the PHP or the PHMP to be certain they know their rights under these programs and the advantages and disadvantages of each program. Careful planning of communicating these issues with employers and hospital administration will preserve those rights to the fullest extent and help return the impaired physician to health and active practice.

About the Health Law Practice

Fox Rothschild's Health Law Practice has earned its reputation as a leading national health law practice. With more than 50 attorneys practicing in 14 offices across the United States, our multi-office, multi-disciplinary approach allows us to offer practical, cost-effective solutions to issues faced by longstanding stakeholders, as well as a variety of industry newcomers.

For more information about any of the articles in the Health Law newsletter, please contact any member of the Fox Rothschild Health Law Practice. Visit us on the web at www.foxrothschild.com.

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