**IN THE SUPREME COURT OF OHIO**

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| **MEDICAL MUTUAL OF OHIO,**<br><br>*Appellant,*<br><br>v.<br><br>**WILLIAM SCHLOTTERER, D.O.,**<br><br>*Appellee.* | SUPREME COURT OF OHIO<br>CASE NO. 2008-0598<br><br>**ON APPEAL FROM THE CUYAHOGA COUNTY COURT OF APPEALS, EIGHTH APPELLATE DISTRICT CASE NO. CA-07-089388** |

# BRIEF OF *AMICI CURIAE* NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION, NATIONAL INSURANCE CRIME BUREAU, COALITION AGAINST INSURANCE FRAUD, AND AMERICA'S HEALTH INSURANCE PLANS IN SUPPORT OF MEDICAL MUTUAL OF OHIO


Lisa L. Norris (0061550)
*Counsel of Record*
Allen Kuehnle Stovall & Newman LLP
21 West Broad St.; Suite 400
Columbus, Ohio 43215
T: (614) 221-8500
F: (614) 221-5988
Email: lnorris@aksnlaw.com

Kirk J. Nahra
Howard Anglin
WILEY REIN LLP
1776 K Street, N.W.
Washington, DC 20006
T: (202) 719-7000
F: (202) 719-7049
Email: HAnglin@wileyrein.com

*Attorneys for* Amici Curiae *National Health Care Anti-Fraud Association, National Insurance Crime Bureau, Coalition Against Insurance Fraud and America's Health Insurance Plans*

Stephen Gladstone (0012128)
*Counsel of Record*
Brian E. Roof (0071451)
Brendan Gallagher (0080663)
FRANTZ WARD LLP
2500 Key Center, 127 Public Square
Cleveland, Ohio 44114-1230
T: (216) 515-1660; F: (216) 515-1650
Email: sgladstone@frantzward.com

*Attorneys for Appellant Medical Mutual of Ohio*

D. Jeffery Rengel (0029069)
*Counsel of Record*
Thomas R. Lucas (0071916)
RENGEL LAW OFFICE
421 Jackson Street
Sandusky, Ohio 44870
T: (419) 627-0400; F: (419) 627-1434
Email: djr@toast.net

*Attorneys for Appellee William Schlotterer*

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## INTEREST OF *AMICI CURIAE*

*Amici curiae* have extensive experience and expertise in studying, preventing, investigating and detecting insurance fraud. Representing the entire spectrum of insurance interests—from consumers, to regulators, to law enforcement agencies, to private insurers—*amici curiae* believe this court will benefit from their knowledge of health care fraud and its devastating effects on the nation's health care system.

The National Health Care Anti-Fraud Association ("NHCAA") is the leading national organization focused exclusively on the fight against health care fraud. NHCAA is a private-public partnership whose members include more than 100 private health insurers and those public-sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. NHCAA's mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud.

The National Insurance Crime Bureau ("NICB") is a not-for-profit organization dedicated to preventing, detecting and defeating insurance fraud through data analytics, investigations, training, legislative advocacy and promotion of public awareness. NICB's membership includes more than 1,000 commercial and personal line property/casualty insurers and self-insured organizations. NICB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals.

The Coalition Against Insurance Fraud ("CAIF") is an anti-fraud watchdog representing the interests of consumers, insurance companies, legislators, regulators and others. CAIF and its members work to control insurance costs, protect the public safety, and eliminate insurance fraud

through promoting tough new anti-fraud laws and regulations, educating the public on how to fight fraud, and serving as a national clearinghouse of insurance fraud information.

America's Health Insurance Plans ("AHIP") is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. AHIP's members offer a broad range of products in the commercial marketplace including health, long-term care, dental, vision, disability, and supplemental coverage. AHIP's members also have a strong track record of participation in Medicare, Medicaid, and other public programs.

*Amici Curiae* National Health Care Anti-Fraud Association ("NHCAA"), National Insurance Crime Bureau ("NICB"), Coalition Against Insurance Fraud ("CAIF") and America's Health Insurance Plans ("AHIP"), by and through their attorneys, submit this brief in support of Medical Mutual of Ohio in the above-captioned proceeding and respectfully request that this Court reverse the erroneous decision of the Court of Appeals below.

## I. SUMMARY OF ARGUMENT

This case will decide the question of whether, in the course of a fraud investigation, a health insurer should be able to access the medical records of its own insureds in order to verify the accuracy of suspect billing practices by a health care provider. Put another way, this case will assess whether a physician can use the physician-patient privilege as a shield to hide inappropriate billing practices for care provided to an insurer's members and fraudulently billed to that insurer. The health care provider in this case, Dr. Schlotterer, initially provided a wide range of information about his patients in connection with the original insurance claims now being investigated, while he was seeking payment from Medical Mutual of Ohio ("Medical Mutual") for his services. When Medical Mutual began to investigate these billings, Dr. Schlotterer first agreed to cooperate with Medical Mutual's investigation and provided the information sought with respect to certain of his patients. Once it became clear that he faced substantial liability for submitting fraudulent claims to Medical Mutual, Dr. Schlotterer suddenly reversed his position and refused to cooperate with the investigation, citing the physician-patient privilege. The issue, therefore, is whether Dr. Schlotterer should be permitted to assert the physician-patient privilege to shield himself from a health care fraud investigation, or whether the public interest in supporting a fraud investigation outweighs the extremely narrow privacy interest at stake when Medical Mutual seeks information about its own insureds.

Under well-established Ohio law, the disclosure of otherwise confidential medical records requires a court to balance patient confidentiality against the public interest in disclosure. *Biddle v. Warren Gen. Hosp.*, 86 Ohio St. 3d 395, 402, 715 N.E.2d 518, 524 (1999). In this case, the Court of Appeals either misunderstood or ignored the true interests at stake on both sides of the *Biddle* balancing test. The court failed to appreciate the important public interest—which is shared by Medical Mutual, its employer customers, and its individual insurance members, as well as the overall health care system—in conducting effective health care fraud investigations and rooting out health care fraud. At the same time, the court appeared to assume an essentially absolute privacy right of patients, even when the insurance company seeking disclosure already had access to confidential medical information about the patients and their care, which is common in insurance claim situations where health care providers turn in the details of a patient's treatment in order to be paid for their services. In fact, the court never identified a specific privacy interest that was promoted through its decision in this case. The court's decision to vacate the trial court's protective order was, therefore, doubly erroneous and must be reversed.

First, the Court of Appeals' cursory analysis ignored important public interests that militate in favor of the disclosure of patient records in the context of a fraud investigation. Health care fraud is a massive drain on the American health care system and a violation of the trust that both patients and insurers vest in health care providers. For this reason, rooting out health care fraud is a compelling public interest recognized as such by the federal government and the Ohio Attorney General's Office. Patients, insurers, employers, and the general public (as well as the vast majority of health care providers who provide treatment and bill honestly and appropriately) all have a strong interest in reducing the cost of health insurance, in identifying fraudulent and untrustworthy health care providers, and in guarding against the falsification of

medical records. The Court of Appeals, however, did not even consider this range of interests, which it was required to do under the *Biddle* test. The court thus significantly underestimated the public interest in favor of disclosure.

On the other side of the scale, the Court of Appeals significantly overestimated the privacy interest at stake. This should have been easy case under the *Biddle* test. Beyond the fact that, under the *Biddle* test, medical records should be disclosed to third parties when the public interest favors disclosure, in this case Medical Mutual insured all the patients whose records were sought and had already processed the insurance claims for these patients for the specific treatments at issue. Because Medical Mutual was already privy to information concerning each patient's confidential diagnosis and course of treatment, and this information in fact forms the core basis for the ongoing health insurance relationship that provides benefits to these patients, the privacy interest of those patients vis-à-vis their insurer is minimal. Any remaining privacy interest—for example, in preventing public disclosure of this information—is appropriately governed by a protective order, not by denying Medical Mutual access to the information it needs to investigate Dr. Schlotterer's inappropriate billing. Because of the limited privacy interest in this case, almost any interest at all on the other side of the *Biddle* test should have tipped the scales decisively in favor of disclosure. The court's failure to appreciate the very limited nature of the privacy interest implicated here was a clear analytical oversight that improperly determined the court's conclusion in this case. Because the Court of Appeals did not address all the relevant factors required by the *Biddle* test and misunderstood the factors it did consider, its erroneous conclusion must be reversed.

## II. ARGUMENT

**Proposition of Law No. 1:**

**Reducing health care fraud is a compelling public interest under the *Biddle* test.**

Health care fraud is a pervasive and costly drain on the United States health care system. In 2007, Americans spent $2.25 trillion dollars on health care.[1] Of those trillions of dollars, the Federal Bureau of Investigation estimates that between 3% and 10% was lost to health care fraud.[2] In other words, between $68 billion and $226 billion was stolen from the American public through health care fraud *in a single year*. To put the size of the problem into perspective, $226 billion is approximately the Gross Domestic Product ("GDP") of Portugal and higher than the GDP of 138 countries, including Denmark, Ireland and New Zealand.[3] Because the cost of health care is projected to rise rapidly over the next ten years, *see* HHS Projections, at Table 1 (projecting increase in annual expenditure from $2.25 trillion to $4.28 trillion between 2007 and 2017), the cost of health care fraud is likely to rise as well. *See* FBI Report, at 9 ("Health care fraud is expected to continue to rise as people live longer. . . . These activities are becoming increasingly complex and can be perpetrated by corporate-driven schemes and systematic abuse by providers."). In other words, health care fraud is already a massive problem and is only going to get worse.

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1 *See* Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2007-2017 ("HHS Projections"), at Table 1, *available at* http://www.cms.hhs.gov/ NationalHealthExpendData/Downloads/proj2007.pdf.

2 *See* Federal Bureau of Investigation, Financial Crimes Report to the Public, Fiscal Year 2007 at 9 ("FBI Report"), *available at* http://www.fbi.gov/ publications/financial/fcs_report2007/financial_crime_ 2007.htm.

3 *See* World Bank, Gross Domestic Product 2007, PPP, *available at* http://siteresources.worldbank.org/ DATASTATISTICS/Resources/GDP_PPP.pdf.

The enormous costs of health care fraud are borne by all Americans. Whether you have employer-sponsored health insurance, purchase your own insurance policy, or pay taxes to fund government health care programs, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits or coverage. As Colin Wong, head of California's Medi-Cal fraud unit has explained, "'[h]ealth care fraud often gets overlooked and even trivialized, because it's seen as a victimless paper crime. . . . But, in reality, the financial burden falls on all of us. We pay for it with heightened health care premiums, increased taxes to pay for social service programs or . . . the reduction of services.'" Erin McCormick, *Defrauding Medicare—No End to Flood of Schemes*, San Francisco Chronicle, Apr. 18, 2005, at A1. For employers, health care fraud increases the cost of purchasing health care for their employees, which in turn drives up the cost of doing business. For individuals the effects are more immediate and more devastating: the increased cost of health insurance due to health care fraud can mean the difference between being able to afford health insurance or not. For governments, health care fraud means higher taxes, fewer benefits and increased budgetary problems.

In addition to being a financial problem, health care fraud has a human face. The victims of health care fraud include unsuspecting patients who are subjected to unnecessary or dangerous medical procedures, whose medical records are falsified or whose personal and insurance information is used to submit fraudulent claims. According to the FBI:

> [o]ne of the most significant trends observed in recent health care fraud cases includes the willingness of medical professionals to risk patient harm in their schemes. FBI investigations in several offices are focusing on subjects who conduct unnecessary surgeries, prescribe dangerous drugs without medical necessity, and engage in abusive or sub-standard care practices.

FBI Report, at 10.

For example, in June 2006, Ohio doctor Jorge Martinez was sentenced to life in prison under a statute punishing health care fraud resulting in death. After a five-week trial, a jury convicted Dr. Martinez of 56 charges in connection with his illegal prescription of painkillers that resulted in the death of two of his patients. A contemporary news story described how "Martinez prescribed painkillers only after patients agreed to receive injections to treat pain. . . . Martinez could then bill Medicare, Medicaid, the Ohio Bureau of Workers' Compensation and private insurers for the injections." Mike Tobin, *Physician Gets Life for Drug Deaths*, Cleveland Plain Dealer, June 10, 2006, at A1. According to one federal prosecutor, Dr. Martinez "gave patients only cursory exams but billed insurers for sophisticated treatment . . . He submitted $60 million in fraudulent claims to insurers and received payment on about $12 million – half of which came from the BWC." *Id.* Another prosecutor bluntly summed up the case: "'[Dr. Martinez] pumped people full of pills, jabbed them with needles and lied to insurers solely to get rich . . . And people died.'" *Id.*

Even when health care fraud does not result in death, the victims whose bodies are placed at risk by unscrupulous health care providers are often among the most vulnerable members of society. In March 2004, the Wall Street Journal reported that an FBI investigation had revealed that more than 100 Southern California clinics had "bilked [insurers and employers] out of somewhere between $300 million and $500 million in recent years by claims for unnecessary surgeries." Vanessa Fuhrmans, *FBI Raids Surgery Clinics in Probe—Investigators Say Patients Were Paid to Have Surgery In a $300 Million Scam*, Wall St. J., Mar. 19, 2004, at A7. According to the Wall Street Journal, "doctors perform medically unnecessary and overpriced procedures on patients recruited with cash rewards. The scam has involved thousands of willing patients, often low-income workers recruited from factory floors or assembly lines across the

country, and has affected most large health insurers." *Id.* Investigators reported that "this scam stands out for its scope and level of organization, and because people involved underwent unnecessary surgeries and other procedures, including endoscopy and sweat-gland removal." *Id.* It is not, therefore, surprising that "[h]ealth care fraud investigations are among the highest priority investigations within the FBI's White Collar Crime Program, ranking behind only public corruption and corporate fraud." FBI Report, at 10.[4]

The toll of this sort of health care fraud on patients whose bodies are risked for personal gain is both obvious and severe, but even less-obviously harmful forms of health care fraud can have subtle effects that may not reveal themselves for years after the fraud is committed. For example, if a health care provider alters a patient's medical record in order to support reimbursement for a more expensive treatment than is warranted (whether or not the treatment is actually provided), this false diagnosis becomes part of the patient's documented medical history. Such an erroneous medical history can have serious, unseen consequences: the victim may unknowingly receive the wrong medical treatment from a future provider; he may have difficulty obtaining life insurance or individual health insurance coverage or may find coverage much more expensive; or he may fail a physical examination for employment because of a disease or condition wrongly recorded in his medical record. Untangling the web of deceit spun by perpetrators of medical identity theft can be a grueling and stressful endeavor. The effects of this crime can plague a victim's medical and financial status for years to come. *See, e.g.*, Jospeh

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[4] Patient safety is not merely a speculative concern in this case. Shortly after the trial court rendered its decision, Dr. Schlotterer was suspended by the State Medical Board of Ohio for not less than 90 days for "inability to practice according to acceptable and prevailing standards of care due to use or abuse of alcohol." *See* State Medical Bd. of Ohio, Formal Action Report—March 2007, at 6.

Menn, *ID Theft Infects Medical Records*, Los Angeles Times, Sept. 25, 2006, at A1 (describing ordeal of victim of health care related identity theft as a "40-hour-a-week job").

Finally, health care fraud undermines the reputation of all physicians and health care providers, who are tainted by the dishonesty of a small minority who abuse the trust of their patients and insurers. Because of the private nature of medical diagnoses, the impersonality of insurance reimbursement, and the confidentiality that is generally—and rightly—accorded to medical records, fraud is exceedingly difficult to identify and redress. These protections mean that a health care provider bent on deception has ample room to work behind a built-in shield for his crime. For this reason, health care fraud investigations serve a vital role in policing fraud and in safeguarding the integrity of the American health care system.

Given the impact on individual victims—both direct and indirect—described above, it is clear that "[h]ealth care fraud is not a victimless crime." FBI Report at 14. The seriousness of the threat and the enormity of the challenge posed by health care fraud cannot be overstated. As the FBI has bluntly summarized the problem, "[health care fraud] increases healthcare costs for everyone. It is as dangerous as identity theft. Fraud has left many thousands of people injured. Participation in health care fraud is a crime. Keeping America's health system free from fraud requires active participation from each of us." *Id.* For all these reasons, the threats to patients and to the health care system posed by fraud must be weighed seriously in any decision to disclose or withhold medical records in the context of a health care fraud investigation. Any decision, like the Court of Appeals' decision in this case, that fails to consider the necessity of fraud investigations in rooting out health care fraud is, for that reason alone, intrinsically flawed.

**Proposition of Law No. 2:**

**The Court of Appeals underestimated the compelling public interest in reducing health care fraud in its application of the *Biddle* test.**

This Court must decide whether the trial court below was correct in its judgment that the physician-patient privilege cannot be used by a physician to frustrate an insurance fraud investigation into the physician's billing practices when the privacy interest at stake is both limited and appropriately protected. As this Court has observed, "there existed no physician-patient privilege at common law." *State Med. Bd. v. Miller*, 44 Ohio St. 3d 136, 140, 541 N.E.2d 602, 605 (1989) (citation omitted). "Therefore, because the privilege is in derogation of the common law, it must be strictly construed against the party seeking to assert it." *Id.* In this case, not only did the Court of Appeals construe the physician-patient privilege strictly *in favor* of the party that asserted it, the court also failed to appreciate how substantial the public interest in disclosing medical records to assist fraud investigations actually is.

The physician-patient privilege "is designed to create an atmosphere of confidentiality, which theoretically will encourage the patient to be completely candid with his or her physician, thus enabling more complete treatment." *Miller*, 44 Ohio St. 3d at 139, 541 N.E.2d at 605. The privilege, however, is far from absolute. While this Court has described the "laudable purpose and goal to be achieved by the physician-patient privilege," it has also cautioned that "we are likewise cognizant that the privilege may not be invoked automatically in all circumstances." *Id.* It is well-established, for example, that a physician may disclose otherwise confidential information about a patient when "disclosure is necessary to protect or further a countervailing interest which outweighs the patient's interest in confidentiality." *Biddle*, 86 Ohio St. 3d at 402, 715 N.E.2d at 524. "More important, the privilege to disclose is not necessarily coextensive with a duty to disclose" because "'[e]ven without such a legal obligation, there may be a privilege to

disclose information for the safety of individuals *or important to the public in matters of public interest.*'" *Id.* (quoting *Humphers v. First Interstate Bank*, 696 P.2d 527, 535 (Ore. 1985)) (emphasis added). Indeed, such latitude for disclosure is a necessary corollary of the physician-patient privilege because, "[a]lthough public policy favors the confidentiality [of physician-patient communication], there is a countervailing public interest to which it must yield in appropriate circumstances. . . . Thus, special situations may exist where the interest of the public, the patient, the physician, or a third person are of sufficient importance to justify the creation of a conditional or qualified privilege to disclose in the absence of any statutory mandate or common-law duty." *Id.* (internal quotation marks and citation omitted). In this case, the Court of Appeals significantly underestimated the public interest in disclosure and then compounded its error by vastly overstating the privacy interest at stake.

1. The Court Failed to Consider the Interests of the Public, Patients and Third Parties, as Required by the *Biddle* Test.

The *Biddle* balancing test admonishes courts to consider the interests of four categories of persons—"the public, the patient, the physician, or a third person"—to determine if they outweigh the interests of patients in preserving the confidentiality of their medical records. The Court of Appeals' opinion, however, focused exclusively and much too narrowly on what it believed to be the interests of Dr. Schlotterer's patients (without explaining what those interests were) and completely ignored the compelling public interest in supporting health care fraud investigations and the interests of third parties, including insurers. *Med. Mut. v. Schlotterer*, No. 89388, 2008 WL 94508, at *4-*5 (Ohio App., Jan. 10, 2008). Because the Court of Appeals drastically underestimated the public interests that favor disclosure in this case—including the interests of Dr. Schlotterer's own patients, the general public, health care insurers such as Medical Mutual, and the vast majority of honest health care providers—its application of the

*Biddle* test was improperly skewed against the public interest and the court's decision was thus a foregone and erroneous conclusion.

First, the court took an extremely narrow view of the patients' own interests in disclosure. The court did not appear to understand that Dr. Schlotterer's own patients have a direct and personal stake in investigating fraud committed by Dr. Schlotterer that implicates their medical or insurance histories. Medical Mutual's discovery request would further the interest of establishing Dr. Schlotterer's persistent, fraudulent manipulation of his patients' medical and insurance records, which is a compelling interest justifying disclosure.

Second, the court ignored the vital importance to Ohio's health care system of rooting out health care fraud. As discussed in Proposition of Law No. 1, *supra*, health care fraud has wide-ranging and devastating effects on the people of Ohio and on the state's health care system, including driving up the price of health insurance for individuals, businesses and government, in addition to the direct effects on the unwitting victims of health care fraud. For all these reasons, Ohio, in common with virtually every other state, has made health care fraud a law enforcement priority. In fact, the Ohio Attorney General's office has established a special task force dedicated exclusively to fighting health care fraud, which former Attorney General Jim Petro described as victimizing every citizen of Ohio, and particularly the most vulnerable segment of the population, Ohio's senior citizens.[5]

Tellingly, the federal government has decided that fighting health care fraud is *per se* a sufficiently compelling interest that it justifies disclosure of otherwise confidential medical records in connection with a health care fraud investigation. Indeed, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") strikes exactly the balance envisioned by

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[5] Jim Petro, Ohio Attorney General's Office—Report on Health Care Fraud, 2005, *available at* http://www.ag.state.oh.us/le/prosecuting/pubs/HCFAnnualReport05.pdf.

the *Biddle* test between the compelling public interest in investigating health care fraud, which will almost always require the disclosure of confidential medical records, and patient privacy. For example, HIPAA regulations expressly authorize the disclosure of patient information by a covered entity (a term which includes both health care providers and insurers) in the context of a fraud investigation. *See* 45 C.F.R. § 164.512(b)(1). These resolutions also permit disclosure of patient information as part of a health care provider's or health insurer's "health care operations," where the disclosures are for "fraud and abuse detection" or for "payment"-related activities, such as "review of health care services with respect to medical necessity" or "utilization review activities." *See* 45 C.F.R. § 164.501; 45 C.F.R. § 164.506. Even more broadly, HIPAA regulations authorize health care providers to "disclose protected health information in the course of any judicial or administrative proceeding . . . [i]n response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order." *Id.* § 164.512(e)(1)(i).

Yet the Court of Appeals did not even acknowledge the compelling public interest of reducing health care fraud let alone take it into account, as required by the *Biddle* test, when it weighed the interests in favor of disclosure. *See Biddle*, 86 Ohio St. 3d at 402, 715 N.E.2d at 524. When balanced against the minimal privacy interests that are implicated when an insurer is given access to a physician's records to verify diagnoses and courses of treatments included in claims submitted to the insurer, the public interest in preventing health care fraud overwhelms the asserted privacy interest and the *Biddle* test compels disclosure of the records. *Cf. Miller*, 44 Ohio St. 3d at 140, 541 N.E.2d at 606 ("Against the interest of the patient . . . must be balanced the interest of the public in detecting crimes in order to protect society. . . . We feel that the interest of the public at large, served here through the board's investigation of possible

wrongdoing by a licensed physician, outweighs the interests to be served by invocation of the physician-patient privilege."). Because the Court of Appeals failed to consider the most compelling interest in favor of disclosure in its application of the *Biddle* test, its conclusion was fatally compromised and must be reversed.

The interest in preventing fraud is particularly acute in this case as Dr. Schlotterer has a history of billing irregularity. On March 17, 2005, the Ohio Auditor of State issued a report describing the results of its investigation into Dr. Schlotterer's billing for Medicaid services.[6] The Auditor's investigation "took exception in whole or in part with billings for 99 of the 103 services in [its] samples" and revealed at least $33,000 in charges that appeared to be up-coded in exactly the same way alleged by Medical Mutual in this case, to lack sufficient documentation, or to pertain to uncovered services. *Id.* at 6. The Auditor's report describes how Dr. Schlotterer issued a check for the entire amount identified in the investigation and how, "[i]n lieu of a corrective action plan to correct the deficiencies identified in our report, [Dr. Schlotterer] told us he planned to no longer participate in the Medicaid program." *Id.*

Third, the Court of Appeals downplayed the interest of Medical Mutual in reducing health care fraud by describing it as merely "pecuniary." *Schlotterer*, 2008 WL 94508, at *5. This assessment was incredibly shortsighted. The interests of Medical Mutual in investigating likely cases of health care fraud are exactly aligned with the interests of the public, the interests of Medical Mutual's customers, who are primarily Ohio companies providing health insurance to their employees and, indeed, of Dr. Schlotterer's patients themselves. All of these parties share a common interest in preventing health care fraud, ensuring the accurate diagnosis of illness and

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[6] Betty Montgomery, Auditor of State, Ohio Medicaid Program Audit of Medicaid Reimbursements Made to Dr. William L. Schlotterer, D.O., March 17, 2005, *available at* http://www.auditor.state.oh.us/auditsearch/Reports/2005/William_Schlotterer_Erie_FinalReport.pdf.

the prescription of appropriate treatments, maintaining integrity of medical records, keeping health insurance affordable, and identifying fraudulent physicians. That Medical Mutual also has a financial interest in rooting out health care fraud is immaterial; what matters in weighing the interests in favor of disclosure are the *actual effects* of Medical Mutual's vigilant pursuit of health care fraud and those effects benefit all the parties identified in *Biddle* as having a relevant interest in the disclosure of medical records. The Court of Appeals also overlooked the fact that Medical Mutual's "pecuniary" interest is shared by its insureds. Most of Medical Mutual's customers are employers and their employees, who have a strong interest in reducing the cost of health care coverage. All of Dr. Schlotterer's patients whose records are at issue in this case, along with all of Medical Mutual's other insureds, benefit directly from the reduced cost of health insurance that results from Medical Mutual's rigorous enforcement of its anti-fraud programs.

Moreover, contrary to the Court of Appeals' dismissal of Medical Mutual's interests, the *Biddle* test expressly *requires* courts to consider the interests of "third parties" other than patients, physicians or the general public. Again, the court's analysis of the true interests of all the parties in this case was regrettably superficial. In fact, the pecuniary and non-pecuniary interests of an insurer are exactly consistent with both the pecuniary and non-pecuniary interests of its insured patients and the general public. It was thus wrong both as a matter of fact and of policy to dismiss the Medical Mutual's interests as being merely pecuniary. Because the Court of Appeals' analysis was flatly inconsistent with the analysis required by *Biddle*, its conclusion must be reversed.

2. The Court Improperly Downplayed the Interests of Medical Mutual While Ignoring the Self Serving Position of Dr. Schlotterer.

While the Court of Appeals characterized Medical Mutual's interests in disclosure as purely self-serving, the court was much more generous to Dr. Schlotterer, with much less reason. In contrast to its skeptical attitude towards Medical Mutual's motives, the court expressed no interest in the extent to which Dr. Schlotterer's assertion of the physician-patient privilege was motivated by his own interest in limiting his liability and preventing access to what are presumably inappropriate billing records, rather than by the actual interests of his patients. In fact, much of the "private" information "protected" by Dr. Schloterrer had been provided to Medical Mutual originally as part of the insurance claims process to support Dr. Schlotterer's receipt of payment for his services. Moreover, the record shows that Dr. Schlotterer initially agreed to cooperate with Medical Mutual's investigation and initially provided the information that Medical Mutual now seeks with respect to several of his patients. *See* Memorandum in Support of Jurisdiction of Appellant Medical Mutual at 4 (filed Mar. 27, 2008) ("Medical Mutual Mem."), at 4. Perhaps no coincidentally, Dr. Schlotterer's sudden concern for the confidentiality of his patients' records coincided with his realization that Medical Mutual's investigation could result in significant liability on his part. *Id.* at 5.

Ohio courts have, however, consistently rejected attempts to invoke the physician-patient privilege as a shield from potential liability. *See, e.g., State v. McGriff*, 109 Ohio App. 3d 668, 670, 672 N.E.2d 1074, 1075 (1996) (noting that "neither physicians nor hospitals may shield themselves from criminal investigation by asserting the physician-patient privilege" and "[c]ourts have consistently rejected attempts by physicians or hospitals to assert a patient's privilege to hide their own 'criminal' wrongdoing") (internal quotation marks and citations omitted); *Ohio State Dental Bd. v. Rubin*, 104 Ohio App. 3d 773, 775, 663 N.E.2d 387, 388

(1995) (noting that this Court has "acknowledged the laudable purpose [of] patient confidentiality . . . but determined that the privilege cannot be permitted to be invoked automatically as a means of hindering investigations into suspected medical wrongdoing."); *cf. Miller*, 44 Ohio St. 3d at 141, 541 N.E.2d at 606 (holding that a physician cannot invoke the physician-patient privilege to frustrate an investigation into the physician's illegal prescription of controlled substances).

The case of *Fair v. St. Elizabeth Medical Center* is instructive in marking the limits of the use of the physician-patient privilege as a personal shield by health care providers. In *Fair*, the plaintiff, who had been assaulted by another patient at a hospital, sought access to her attacker's medical history in order to establish that the hospital had a duty to protect her from a patient known to be violent. The hospital refused to provide the attacker's medical history, citing the physician-patient privilege, and the trial court denied the plaintiff's motion to compel. On appeal, the Court of Appeals ruled that allowing the hospital to hide behind a privilege that belonged to the patient in question and not to the hospital itself "would be inherently unfair." 136 Ohio App. 3d 522, 527, 737 N.E.2d 106, 109 (2000). The court was particularly concerned that "[t]here is a conflict in motives behind [the hospital's] argument for nondisclosure, and we cannot determine if [the hospital] is pursuing the underlying purpose of confidentiality and the physician-patient privilege, or if [the hospital] is asserting the self-serving purpose of precluding any further investigation and thus protecting the hospital from potential liability." *Id.* "Accordingly," the court ruled, "we find that under . . . *Biddle*, this is a special situation where disclosure must be made to protect [the plaintiff's] rights." *Id.*

This case presents the same quandary that the court faced in *Fair*. As in *Fair*, there is good reason to believe that Dr. Schlotterer's assertion of privilege on behalf of his patients is

motivated by "the self serving purpose of precluding any further investigation and thus protecting [him] from potential liability," *id.*, rather than by legitimate concerns about patient confidentiality. This suspicion is grounded in Dr. Schlotterer's initial cooperation with Medical Mutual's investigation, and by his initial willingness to divulge the same confidential information he now fights to withhold—beginning with his submission of confidential information in connection with the initial insurance claims and continuing right up until the point it became clear that his potential liability for fraudulent billing was significant. Indeed, Dr. Schlotterer asserted the privilege only in connection with the information Medical Mutual needed to complete its investigation and calculate its injury from these inappropriate billings. The only party that benefits from Dr. Schlotterer's belated and vicarious assertion of his patients' privilege is Dr. Schlotterer. But the physician-patient privilege exists to protect patients, not their physicians. Here, where the privacy interests of Dr. Schlotterer's patients vis-à-vis Medical Mutual, their insurer, is *de minimis*, and where all other interests of the patients are in line with the public interest in investigating and stamping out fraudulent health care billing, the physician-patient privilege must yield.

**Proposition of Law No. 3:**

**Courts must consider the importance to a party's case of access to medical records in deciding when medical records should be disclosed during litigation.**

In addition to weighing the competing interests for and against disclosure under the *Biddle* test, courts have generally favored disclosure when the medical records in question are necessary to further the case of the party seeking disclosure.

In *State v. McGriff*, for example, the Court of Appeals considered whether a physician should be compelled to produce patient records that the state alleged contained evidence of criminal wrongdoing. In analyzing whether the physician-patient privilege should yield to the

state's obvious interest in deterring wrongdoing, the court noted that "[s]ince the defendant has been accused of prescribing controlled substances for improper and illegal purposes and of committing fraud against various health insurance companies, if there is evidence of wrongdoing it will be contained in . . . his patients' medical records." 109 Ohio App. 3d at 670, 672 N.E.2d at 1075. Because the court recognized that, "*[w]ithout these records, the state [would have been] unable to prosecute its case*," it held that the physician must produce his patients' medical records, subject to appropriate redactions to preserve confidentiality. *Id.* (emphasis added).

In a similar case, *Richards v. Kerlakian*, the Court of Appeals' analysis was even more clearly influenced by the necessity of discovery. After briefly weighing the interests for and against disclosure under the *Biddle* test, the court turned to the question of why the plaintiff needed access to the medical records it sought. "In this case," the court explained, "the plaintiffs requested the medical documents to develop a primary claim against Good Samaritan [Hospital] on the issue of negative credentialing. *It is difficult to imagine how else the negligent-credentialing claim could have been investigated without the disputed documents.*" 162 Ohio App. 3d 823, 825-26, 835 N.E.2d 768, 770 (2005). The court contrasted this intended use of the patients' medical files with a case in which it denied disclosure of medical records when the party seeking disclosure intended to use records solely to impeach expert witness testimony. *Id.* at 826, 835 N.E.2d at 770. The court ultimately concluded that, on balance, the physician-patient privilege could not prevent disclosure of otherwise confidential patient records (subject to an appropriate protective order) when "the risk of disclosure" was outweighed by "plaintiffs' *compelling need* for the information." *Id.* (emphasis added).

Just as in *McGriff* and *Richards*, the back-up information sought from Dr. Schlotterer's patient records is absolutely necessary to Medical Mutual's prosecution of its case against Dr.

Schlotterer. Medical Mutual has averred that the information it seeks is "essential for Medical Mutual to prove its claims and to defend against [Dr. Schlotterer's] counterclaims," Medical Mutual Mem. at 13 n.4, and common sense supports Medical Mutual's position. Without access to the documentation supporting Dr. Schlotterer's billing, it will impossible for Medical Mutual ever to verify the accuracy of such billing and to prove its case against Dr. Schlotterer. Where an insurer has good reason to believe that a physician has engaged in fraudulent billing, examination of the physician's underlying records is the only way to validate the insurer's claim or to vindicate the physician. Under circumstances such as this, the physician-patient privilege must yield both to the compelling public interest in disclosure, as required by *Biddle*, and to the insurer's "compelling need for the information." *Richards*, 162 Ohio App. 3d at 826, 835 N.E.2d at 770.

**Proposition of Law No. 4:**

**The Court of Appeals vastly overestimated the privacy interest at stake in this case.**

The Court of Appeals appeared to begin with the assumption that there was a strong privacy interest at stake in this case. In fact, this was one of the easiest privilege cases a court could encounter. As described above, under *Biddle* otherwise confidential records may be disclosed to a third-party with no prior relationship to the patient in question when there is a compelling public interest in disclosure. *See Biddle*, 86 Ohio St. 3d at 402, 715 N.E.2d at 524; *Richards*, 162 Ohio App. 3d at 826, 835 N.E.2d at 770; *Cepeda v. Lutheran Hosp.*, No. 90031, 2008 WL 2058588, at *2 (Ohio Ct. App. May 15, 2008). However, that scenario is not presented in this case. In this case, the party requesting medical records already had access to most of the medical history of the patients in question. There is thus virtually no privacy interest left to be

protected by the physician-patient privilege and the *Biddle* test tips decisively in favor of disclosure. Granting Medical Mutual's request should have been a simple decision.

1. The Court Failed to Take into Account the Position of Medical Mutual vis-à-vis the Patients Whose Records It Sought.

Given the limits of the physician-patient privilege described by this Court, the facts of this case simply do not justify Dr. Schlotterer's invocation of the privilege against Medical Mutual. As Medical Mutual explained, "Medical Mutual was not . . . unreasonably seeking to pry into confidential information concerning a patient's identifying information, diagnosis, or treatment." Medical Mutual Mem. at 5. Indeed, because Medical Mutual insures every patient whose records were sought in discovery, "in processing claims for payment pursuant to CPT Codes, Medical Mutual already has that information, including the patient's name, address, social security number, medical diagnosis and treatment." *Id.* All that Medical Mutual sought in discovery was the back-up documentation that Dr. Schlotterer was required to maintain with respect to each diagnosis and insurance claim in order to verify that the level of treatment indicated by Dr. Schlotterer's billing was justified.

In the usual course, when a health care provider submits a claim to an insurer, the insurer is entitled to examine the health care provider's notes and medical records in order to verify the legitimacy of the claim. *See* Kelly Aff. 1, Oct. 10, 2006 (attached to Medical Mutual Motion for Protective Order as Ex. C.) (quoting language from Medical Mutual's Certificate of Coverage informing insured that Medical Mutual "may require Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage"). In other words, the information that Medical Mutual sought in discovery is the same information that Medical Mutual indisputably would be entitled to examine before paying out an insurance claim. Nothing happened to the information between the time Medical Mutual ordinarily would see it

and the time Medical Mutual requested it in this case. This is a crucial point, because if the physician-patient privilege does not bar Medical Mutual from reviewing Dr. Schlotterer's notes during the claim-handling process, there is no logical reason why the privilege would suddenly attach, at least with respect to Medical Mutual, at some arbitrary time thereafter. To see why this must be so, consider the situation in which Medical Mutual properly requests—and is provided—a doctor's notes in support of a specific patient's diagnosis and treatment before Medical Mutual decides to pay the claim. If, some time later, in the course of a broader investigation into a pattern of fraudulent billing by the doctor, Medical Mutual asks to review the same notes again in order to compare them to other patients' notes, it would be absurd to object that the physician-patient privilege prevents this second disclosure of the same information to the same party.

Because disclosure of otherwise confidential information to an insurer is a necessary part of the insurance process, there is nothing about Medical Mutual's discovery request that is inconsistent with the physician-patient privilege. Nor would Medical Mutual's discovery request undermine the purpose of the privilege as described by this Court. To the contrary, Medical Mutual's discovery request would further the goal of the physician-patient privilege of "enabling more complete [*i.e.*, accurate] treatment." *Miller*, 44 Ohio St. 3d at 139, 541 N.E.2d at 605. Because Medical Mutual is already privy to the confidential information that is usually the subject of the physician-patient privilege—*i.e.* the actual diagnoses and treatments of the patients for whose billing Medical Mutual sought back-up documentation—Medical Mutual's discovery request does not interfere with the purpose of the physician-patient privilege as described by this Court. Moreover, had Medical Mutual requested this information from Dr. Schlotterer before he had been reimbursed for his services, he would have been *required* to provide it to Medical

Mutual to justify his billing. There is no reasonable justification for now withholding the very same information from Medical Mutual on the grounds of the physician-patient privilege.

Even if the core purpose of the physician-patient privilege were implicated by Medical Mutual's discovery request—which it is not—this Court's decision in *Biddle* established that the disclosure of patient information to a third party is appropriate when there is a compelling public interest. The *Biddle* test requires a court to balance two competing sets of interests. On the one hand, the court must weigh the interest of the patient in confidentiality; on the other, the court must weigh the public interest (which is defined to encompass the interests of the general public, the patient, the physician, or a third party) in disclosure. *See Biddle*, 86 Ohio St. 3d at 402, 715 N.E.2d at 524. In this case, the first interest—the interest in maintaining confidentiality—is *de minimis* because Medical Mutual, as the insurance company for all of the patients whose records are at issue, already has access to their otherwise confidential medical records. Certainly, at a minimum, the confidentiality interest is substantially lower than in a typical case, in which the party seeking disclosure has no prior knowledge of the patients' diagnoses or treatments and would be learning such private and potentially embarrassing information for the first time. Because the confidentiality interest is so abnormally low in this case, the *Biddle* test tips strongly in favor of disclosure and almost any public interest on the other side of the equation will outweigh the narrow privacy interest in this case.

2. The Court Improperly Discounted the Ability of a Protective Order to Prevent Disclosure of Confidential Patient Information to Parties other than Medical Mutual.

To the extent there is any concern about disclosure of confidential information to parties other than Medical Mutual, that concern was properly addressed by the trial court's protective order (in addition to the wide range of other restrictions imposed by HIPAA and otherwise on how Medical Mutual can use and disclose this information). The Court of Appeals objected to

the form of the protective order imposed by the trial court in this case because "no time frame was included and, it was not limited to patients who were treated under the '99215' code." *Schlotterer*, 2008 WL 94508, at *5. The court's objections were misplaced for at least two reasons and its decision to vacate the trial court's protective order entirely was, in any case, the wrong remedy.

First, the protective order approved by the trial court complies with the requirements of HIPAA, which strikes exactly the same balance that the *Biddle* test seeks to achieve between patient privacy and the necessity of disclosure when countervailing public interests require it. To that end, the federal government has determined that fraud investigations are a compelling interest justifying disclosure of confidential medical information, *see* 45 C.F.R. § 164.506(c)(4)(ii), but HIPAA regulations also provide restrictions on the information that can be disclosed and the manner of disclosure, *see id.* § 164.512(e). The protective order approved by the trial court in this case satisfies the requirements of 45 C.F.R. § 164.512(e), which is strong evidence that the Court of Appeals' concern about the order's ability to prevent unnecessary disclosure of confidential information was misplaced.

Second, the Court of Appeals' complaint that "no time frame was included [in the trial court's order to produce patient records] and, it was not limited to patients who were treated under the '99215' code" ignores the fact that Medical Mutual already has access to the most medically sensitive information about all of the patients whose records were covered by the protective order (including information previously submitted to them by Dr. Schlotterer in connection with their insurance claims) whether their information was relevant to the lawsuit or not. For this reason, the purpose of the protective order was not to limit the information available to Medical Mutual, but to prevent the wider *public* disclosure of information that

Medical Mutual is already entitled to review. Accordingly, the scope of the information made available to Medical Mutual in discovery should not be a relevant factor in assessing the effectiveness of the protective order; rather, the relevant question in this case was whether the protective order imposed by the trial would prevent the disclosure to parties *other than Medical Mutual*. Because the protective order in this case met all the requirements of the federal HIPAA regulations—which, like the *Biddle* test, are designed to balance patient privacy with the need for disclosure in fraud cases—there was no reason to second guess the trial court's order.

Finally, if there were any remaining concern that the protective order was not sufficiently stringent in its protection of confidential patient information under Ohio law, the proper remedy would have been to remand the case with express instructions to the trial court to amend the order. In *Fair*, the Court of Appeals balanced the public interest in disclosure of medical records with a patient's privacy interest by ordering the court to limit public access to the patient's medical records. As that court explained, "[t]he purpose of the privilege statute is to 'create an atmosphere of confidentiality, encouraging the patient to be completely candid and open with his or her physician, thereby enabling more complete treatment.' . . . A redaction of all identifying information of the patient would preserve the purpose of the privilege, protect the [patient's] identity, yet still provide relevant information." 136 Ohio App. 3d at 527, 737 N.E.2d at 110; *see also Richards*, 162 Ohio App. 3d at 824, 835 N.E.2d at 769 (approving the production of confidential medical records subject to a protective order "designed to protect the identities of the former patients"); *McGriff*, 109 Ohio App. 3d at 670, 672 N.E.2d at 1075 ("Redaction of the records through erasure or concealment of the patients' names and addresses and other information inapplicable to the prosecution of the charged crimes, would assure that each patient's interest in confidentiality and privacy is protected without frustrating the state's interest

in prosecuting illegal drug activity."); *cf. Miller*, 44 Ohio St. 3d at 138, 541 N.E.2d at 603 ("Because the statute in question contains safeguards designed to protect patient confidentiality, which is the same purpose served by the physician-patient privilege, we find that the physician-patient privilege does not preclude turning patient records over."). There is no reason why the court in this case also could not have drafted an appropriate protective order that would have permitted the use of the records in question in discovery and at trial but prevented their disclosure to the broader public.

In *Cepeda*, a case decided only a few months after this case by the very same Court of Appeals, the court noted that discovery of properly redacted or sealed records is permitted in Ohio because "[s]hielding the identity preserves the objective of the patient-physician privilege while still achieving the public's interest in justice." 2008 WL 2058588, at *2. In contrast to its decision in this case, the court in *Cepeda* approved disclosure in part because "the trial court provided adequate protection for the identity of the non-party patients and protected against dissemination of the information sought by ordering redaction of certain information from the reports and ordering that the records be filed with the court under seal." *Id.* at *3. The Court of Appeals' concern about the sufficiency of the protective order in this case is flatly inconsistent with its more reasonable approach in *Cepeda*. If patient information could be adequately protected and yet be disclosed in *Cepeda*, it can be protected and disclosed in this case as well.

If the Court of Appeals had any doubts about whether the protective order approved by the trial court was sufficient to protect the patients' confidential information from disclosure to any party other than Medical Mutual, the court should have followed the examples of *Fair*, *Richards*, *McGriff*, and *Cepeda* and imposed a solution that balanced the need for disclosure with due solicitousness for patient privacy. To the extent the Court of Appeals' concerns about the

adequacy of the protective order played any part in its decision to overrule the trial court's discretion in approving the protective order, its decision must be reversed.

## III. CONCLUSION

For the reasons set forth above and in the Brief of Appellant Medical Mutual of Ohio, this Court should reverse the decision of the Court of Appeals below.

Respectfully submitted,

Dated: August 29, 2008

ALLEN KUEHNLE STOVALL & NEUMAN LLP

Lisa L. Norris (0061550), Counsel of Record
Allen Kuehnle Stovall & Newman LLP
21 West Broad St.
Suite 400
Columbus, Ohio 43215
(614) 221-8500

Kirk J. Nahra
Howard Anglin
WILEY REIN LLP
1776 K Street, N.W.
Washington, DC 20006
(202) 719-7000

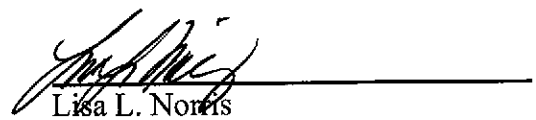
*Attorneys for* Amici Curiae *National Health Care Anti-Fraud Association, National Insurance Crime Bureau, Coalition Against Insurance Fraud and America's Health Insurance Plan*

**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the foregoing has been served upon the following by regular U.S. Mail, postage prepaid, this 29 day of August, 2008:

Stephen F. Gladstone
Brian E. Roof
FRANTZ WARD LLP
2500 Key Center, 127 Public Square
Cleveland, Ohio 44114-1230

D. Jeffery Rengel
Thomas R. Lucas
RENGEL LAW OFFICE
421 Jackson Street
Sandusky, Ohio 44870



Lisa L. Norris

# APPENDIX

## Unreported Cases



## Regulations, Other

# Court of Appeals of Ohio

EIGHTH APPELLATE DISTRICT
COUNTY OF CUYAHOGA

JOURNAL ENTRY AND OPINION
**No. 90031**

## MARIA CEPEDA, ET AL.

PLAINTIFFS-APPELLEES

vs.

## LUTHERAN HOSPITAL, ET AL.

DEFENDANTS-APPELLANTS

**JUDGMENT:**
**AFFIRMED**

Civil Appeal from the
Cuyahoga County Court of Common Pleas
Case No. CV-566589

**BEFORE:** Dyke, J., Kilbane, P.J., and Blackmon, J.

**RELEASED:** May 15, 2008

**JOURNALIZED:** MAY 2 7 2008

**ATTORNEYS FOR APPELLANTS**

Ingrid Kinkopf-Zajac, Esq.
Anna M. Carulas, Esq.
Roetzel & Andress
1375 East Ninth Street
One Cleveland Center, Suite 900
Cleveland, Ohio 44114

**ATTORNEYS FOR APPELLEES MARIA CEPEDA, ET AL.**

Rachael May Weiser, Esq.
Jay Milano, Esq.
Milano & Weiser
2639 Wooster Road
Rocky River, Ohio 44116

**ATTORNEYS FOR APPELLEE LUTHERAN HOSPITAL**

Sandra M. DiFranco, Esq.
Rita A. Maimbourg, Esq.
Tucker, Ellis & West, LLP
1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, Ohio 44115-1475



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N.B. This entry is an announcement of the court's decision. See App.R. 22(B), 22(D) and 26(A); Loc.App.R. 22. This decision will be journalized and will become the judgment and order of the court pursuant to App.R. 22(E) unless a motion for reconsideration with supporting brief, per App.R. 26(A), is filed within ten (10) days of the announcement of the court's decision. The time period for review by the Supreme Court of Ohio shall begin to run upon the journalization of this court's announcement of decision by the clerk per App.R. 22(E). See, also, S.Ct. Prac.R. II, Section 2(A)(1).

ANN DYKE, J.:

Defendants-appellants, Ali S. Halabi, M.D., and Ali S. Halabi, M.D., Inc. ("defendants"), appeal the trial court granting plaintiffs' motion to compel. For the reasons set forth below, we affirm.

On July 11, 2005, plaintiff-appellee, Maria Cepeda, filed a complaint against defendants, Lutheran Hospital, The Cleveland Clinic Foundation and David F. Perse, M.D., and averred Dr. Halabi inappropriately and unnecessarily removed her uterus and ovaries. In the complaint, she alleged medical malpractice, lack of informed consent, assault and battery, intentional and negligent infliction of emotional distress, unauthorized practice of medicine, and negligent hiring/negligent credentialing/ corporate negligence. Her husband, Erasmo, and her four children, Nestor, Natanael, Madailissa and Michael, filed loss of consortium claims against each of the aforementioned defendants as well. Lutheran Hospital settled with the plaintiffs and subsequently was voluntarily dismissed. Plaintiffs also voluntarily dismissed The Cleveland Clinic and David F. Perse, M.D. from the action. Thereafter, plaintiffs' claims remained pending against defendants only.

On April 27, 2006, plaintiffs' counsel deposed Dr. Halabi. At the deposition, Dr. Halabi refused to answer questions pertaining to billing statements sent to Medicare and Medicaid for all of his patients for the past five

years; his average salary; his income from gynecology; the percentage of his income from gynecology in 2003; and his tax returns for the past five years. Dr. Halabi objected to the questions, arguing they were privileged communications between physician and patient and irrelevant.

On March 5, 2007, plaintiffs filed a motion to compel Dr. Halabi to answer the deposition questions and a motion for expenses. Defendants filed a brief in opposition and motion for protective order on March 15, 2007. The trial court granted plaintiffs' motion to compel on May 25, 2007, but denied the motion for expenses. The court ordered Dr. Halabi to submit to another deposition and to answer questions regarding other patients and his income and finances. The court also ordered the "Deposition transcript to be sealed by order of the court and subject to disclosure only by further order of the court."

Defendants now appeal and assert one assignment of error for our review. Defendants' sole assignment of error states:

"The trial court erred in granting plaintiff-appellee's motion to compel which required defendant-appellant Ali S. Halabi, M.D. to disclose privileged medical information prior to an in-camera inspection that is also irrelevant to the issues in this case."

Defendants contend the trial court erred in granting plaintiffs' motion to compel because the unauthorized disclosure of billing statements of non-party

patients sent to Medicare and Medicaid would violate the patient-physician privilege. Additionally, defendants argue that information regarding Dr. Halabi's finances and income was unnecessary for plaintiffs to pursue their claims. We find defendants' arguments without merit.

First, we will address defendants' contention that questions regarding the billing statements of non-party patients of Dr. Halabi sent to Medicare and Medicaid are confidential under the patient-physician privilege.

As a procedural matter, we note that normally, we review a trial court's decision regarding the management of discovery under an abuse of discretion standard. *Roe v. Planned Parenthood Southwest Ohio Region*, 173 Ohio App.3d 414, 419, 2007-Ohio-4318, 878 N.E.2d 1061. Questions of privilege, however, "including the proprietary of disclosure, are questions of law and are reviewed de novo." Id.

R.C. 2317.02 provides for a testimonial privilege of patient and physician communications. The privilege afforded under R.C. 2317.02, however, is not absolute. *Biddle v. Warren Gen. Hosp.*, 86 Ohio St.3d 395, 402, 1999-Ohio-115, 715 N.E.2d 518. The Ohio Supreme Court has held that the discovery of such protected communications may be appropriate under certain circumstances. Id. First, disclosure is permitted in the absence of prior authorization of privileged matters where disclosure is made pursuant to a statutory mandate or common-

law duty. Id. Second, discovery of such protected communications is appropriate to protect or further a countervailing interest that outweighs the non-party patient's interest in confidentiality. Id.

Ohio Courts have permitted discovery of confidential information to further a countervailing interest only if the non-party patient's identity is sufficiently protected. *Richards v. Kerlakian*, 162 Ohio App.3d 823, 2005-Ohio-4414, 825 N.E.2d 768; *Fair v. St. Elizabeth Med. Ctr.* (2000), 136 Ohio App.3d 522, 737 N.E.2d 106. Shielding the identity preserves the objective of the patient-physician privilege while still achieving the public's interest in justice. In *Terre Haute Regional Hosp., Inc. v. Trueblood* (Ind. 1992), 600 N.E.2d 1358, the Indiana Supreme Court eloquently explained:

"Along with a patient's individual interest in quality medical care, the public has an interest in being protected from incompetent physicians. * * * It is unlikely that a patient would be inhibited from confiding in his physician where there is no risk of humiliation and embarrassment, and no invasion of the patient's privacy. The public policy involved is strong and carries a great societal interest. In situations where the medical records are relevant, a 'blanket prohibition against examination and use against the hospital of such records would result in an injustice.'"

Id. at 1361 (citations omitted).

In *Richards v. Kerlakian*, supra, the plaintiffs sued Dr. Kerlakian after their son died following gastric bypass surgery performed by the doctors. Id. at 824. During litigation, the plaintiffs requested production of all operative reports for gastric bypass surgeries performed on a number of non-party patients by Dr. Kerlakian at Good Samaritan Hospital without prior authorization of these patients. Id. Dr. Kerlakian filed a protective order, arguing disclosure would violate the patient-physician privilege and that the records were irrelevant. Id.

The *Richards* court affirmed the trial court's denial of the protective order and order to produce redacted medical records. Id. at 826. The court determined that the plaintiffs' interest in disclosure outweighed the non-party patients' interest in confidentiality. Id. The requested medical documents were necessary to establish a primary claim against defendants and to impeach portions of Dr. Kerlakian's deposition. Id. at 825-826. Furthermore, the trial court provided adequate protection for the identity of the non-party patients and protected against dissemination of the information sought by ordering redaction of certain information from the reports and ordering that the records be filed with the court under seal. Id. at 826.

The questions regarding the billing statements of all patients sent to Medicare and Medicaid for the past five years are undeniably confidential and

privileged under the patient-physician privilege. See R.C. 2317.02(B)(5)(a). Nevertheless, plaintiffs were entitled to such information, as it was necessary to protect or further a countervailing interest that outweighed a non-party's privilege.

The instant action is analogous to that in *Richards*, supra. Here, plaintiffs sought the discovery of the patients' billing statements in an effort to establish Dr. Hababi's alleged motive to supplement his income by performing unnecessary procedures on patients with Medicare or Medicaid. Plaintiffs sought discovery of information pertaining to non-party surgical patients where the plaintiffs' claims are similarly based on alleged unnecessary surgeries. Such information, in the least, would lead to admissible evidence establishing the necessary elements of plaintiffs' causes of action. Moreover, such evidence responds to alleged defenses, aids in establishing plaintiffs' claims for punitive damages, and replies to defendants' motion for summary judgment in that regard. Accordingly, as in *Richards*, we find such information is necessary to further a countervailing interest that outweighs the non-parties' privilege.

Additionally, the trial court provided for protection against disclosure of the identity of the non-party patients and included language against indiscriminate dissemination of the information sought to be discovered by ordering the deposition be sealed. In its judgment entry granting plaintiffs'

motion to compel, the court added the following language: "Deposition transcript to be sealed by order of the court and subject to disclosure only by further order of the court in connection with trial." Under these circumstances, the trial court did not err in granting plaintiff's motion to compel and in ordering Dr. Halabi to testify.

Defendants further argue that questions regarding billing statements of non-party patients discloses medical information that is protected under the Health Insurance Portability and Accountability Act ("HIPAA"). We disagree.

Generally, HIPAA prohibits health care providers from disclosing a patient's personal health information without their consent. 45 C.F.R. 164.508(a). HIPAA, however, permits disclosure when the healthcare provider is ordered by the court. 45 C.F.R. 164.512(e) states in pertinent part:

"(1) Permitted disclosures. A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

"(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; * * *."

In this case, the trial court issued a written order, limits the information sought to only Dr. Halabi's finances and income, and provides for protection

against the dissemination of that information. Accordingly, the order does not violate HIPAA and defendants' argument in this regard is without merit.

Finally, defendants assert that questions regarding Dr. Halabi's finances are irrelevant and constitute an invasion of his privacy. We disagree. The information sought is relevant and reasonably calculated to lead to admissible evidence.

As previously briefly mentioned, we review the trial court's decisions on the management of discovery matters under an abuse of discretion standard. *Roe v. Planned Parenthood Southwest Ohio Region*, supra. The complaining party must establish a clear and prejudicial abuse of discretion that materially prejudices the party. *O'Brien v. Angley* (1980), 63 Ohio St.2d 159, 163, 407 N.E.2d 490. Absent an abuse of discretion, an appellate court may not overturn the trial court's ruling on discovery matters. *Feichtner v. Cleveland* (1994), 95 Ohio App.3d 388, 397, 642 N.E.2d 657 citing *Vinci v. Ceraolo* (1992), 79 Ohio App.3d 640, 607 N.E.2d 1079.

"Abuse of discretion connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable." *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219, 450 N.E.2d 1140. The Supreme Court of Ohio has explained this standard as follows:

"An abuse of discretion involves far more than a difference in ***opinion***. The term discretion itself involves the idea of choice, of an exercise of the will, of a determination made between competing considerations. In order to have an 'abuse' in reaching such a determination, the result must be so palpably and grossly violative of fact and logic that it evidences not the exercise of will but perversity of will, not the exercise of judgment but defiance thereof, not the exercise of reason but rather of passion or bias." *Huffman v. Hair Surgeon, Inc.* (1985), 19 Ohio St.3d 83, 87, 482 N.E.2d 1248.

Civ.R. 26(B)(1) states in relevant part:

"Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery... It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence."

The relevancy test pursuant Civ.R. 26(B)(1) "is much broader than the test to be utilized at trial. [Evidence] is only irrelevant by the discovery test when the information sought will not reasonably lead to the discovery of admissible evidence." *Tschantz v. Ferguson* (1994), 97 Ohio App.3d 693, 715, 647 N.E.2d 507, citing *Icenhower v. Icenhower* (Aug. 14, 1975), Franklin App. No. 75AP-93.

Under this broad discovery test, questions regarding Dr. Hababi's finances and income are relevant and therefore discoverable. Plaintiffs sought the discovery of Dr. Hababi's finances in an effort to establish his alleged motive to supplement his income by performing unnecessary procedures on patients with Medicare or Medicaid. In the least, such information is necessary to lead to admissible evidence that may establish plaintiffs' claims. Moreover, such evidence counters asserted defenses, assists in establishing plaintiffs' claims for punitive damages, and responds to defendants' motion for summary judgment in that regard. *Svoboda v. Clear Channel Communications, Inc.*, Lucas App. No. L-02-1149, 2003-Ohio-6201 (discovery of defendant's finances and income for punitive damage claim is permitted as it may lead to admissible evidence.) Accordingly, the judgment of the trial court is affirmed.

Judgment affirmed.

It is ordered that appellee recover from appellant costs herein taxed.

The court finds there were reasonable grounds for this appeal.

It is ordered that a special mandate be sent to said court to carry this judgment into execution.

A certified copy of this entry shall constitute the mandate pursuant to Rule 27 of the Rules of Appellate Procedure.

ANN DYKE, JUDGE

MARY EILEEN KILBANE, P.J., CONCURS.
PATRICIA ANN BLACKMON, J., DISSENTS (SEE ATTACHED DISSENTING OPINION)

PATRICIA ANN BLACKMON, J., DISSENTING:

I respectfully dissent from the Majority Opinion. This is not one of those "special situations" envisioned by the Ohio Supreme Court in *Biddle v. Warren Gen. Hosp.*[1] Plaintiff Biddle sued the hospital for unauthorized disclosure of her medical information. The disclosure was induced by the hospital's law firm. The hospital's law firm attempted to collect from the Social Security Administration monies Biddle owed to the hospital, assuming she was eligible. It was uncontested that Biddle owed the hospital money for services it rendered her. The hospital agreed to send her medical information to the law firm. Biddle argued that she did not consent to this disclosure, and the hospital had violated the privilege of confidentiality between it and her. The Ohio Supreme

[1]86 Ohio St.3d 395, 1999-Ohio-115.

Court agreed and held a hospital could be held liable for the unauthorized disclosure of its patients' medical information.

The Ohio Supreme Court also held that the doctor-patient privilege was not absolute; moreover, it held that it is the patient's right to determine who should have access to her medical records. Here, the plaintiff, a patient of the defendant-doctor, seeks to have disclosed the medical records of the defendant-doctor's other patients' who have not consented to this disclosure and are not a party to her lawsuit. This case and others[2] seek to broaden *Biddle's* holding to apply in any case where disclosure is sought to aid a private lawsuit against a doctor who has been accused of malpractice. *Richards v. Kerlakian*[3] is a case similar to this one where the plaintiff-patient sued a doctor for breach of a professional duty. I believe that *Richards* is overreaching and misapplies *Biddle.*

The *Biddle* court used the balancing of "countervailing interest" test to determine whether a patient's medical records can be disclosed to a third party. In order for *Biddle* to apply here, the plaintiff-patient's interest in disclosure must oppose forcefully the interest of the nonparty patient's interest against

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[2]*Richards v. Kerlakian* 162 Ohio App.3d, 823, 2005-Ohio-4414; *Fair v. St. Elizabeth Med. Ctr.* (2000), 136 Ohio App.3d 522.

[3]Supra.

disclosure and protected privacy. This being said, I believe that before a trial court may apply this balancing test, the trial court and this court must define specially what the plaintiff-patient's interest is. This has not been done in this case.

In *Biddle*, the Ohio Supreme Court sought to warn the medical profession and its lawyers that the unauthorized disclosure of confidential medical information will be guarded with the utmost scrutiny. The decisions in this case, *Richards*, and *Fair* are the unintended consequences of *Biddle's* well meaning principle of law.

In fact, the Majority Opinion has joined the more relaxed understanding of *Biddle* and found a judicially created right of injured patients to obtain non-party patients' privileged confidential medical information to punish a wrong inflicted by the patient's doctor. This "super attorney general" concept, designed to personally vindicate a party-patient's welfare, was not sanctioned in *Biddle*. There are remedies against the wrongdoer doctor that could be used, which would not destroy the nonparty patients' privacy, such as, a complaint to the medical board to revoke the doctor's license for using a medical procedure for his economic gain, or a grand jury investigation for potential criminal charges against the doctor.

Assuming our dicta in *Med. Mut. Of Ohio v. Schlotterer* (suggesting that the "countervailing interest" permits disclosure when the welfare of patients are at interest) and *Richards* (patient's right against wrongdoer doctors) are correct and apply in this case, the trial court has not sufficiently protected the identity of the nonparty patients.

The trial court ordered as follows:

> **"Motion to compel and motion for expenses (filed March 5, 2007) is granted in part and denied in part. Motion to compel is granted. Dr. Halabi is to submit to deposition by plaintiff regarding questions of income and finances. Deposition transcript to be sealed by order of the court and subject to disclosure only by further order of the court in connection with trial. Plaintiff's motion for expenses is denied."**

In other cases, the court has permitted the discovery of similar confidential documents, but ordered the patients' names, addresses, and social security numbers redacted. This allows for the patients' identities to be sufficiently concealed. Here, the court did not order redaction. Although the court ordered the deposition of the defendant-doctor to be sealed, at that point, the information has already been disclosed to opposing counsel, which would violate the patients' rights to have their matters kept confidential. Consequently, I would reverse.

plan sponsor consistent with the requirements of this subpart.

* * * * *

(iii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

* * * * *

**§ 164.506 Consent for uses or disclosures to carry out treatment, payment, or health care operations.**

(a) *Standard: Consent requirement.* (1) Except as provided in paragraph (a)(2) or (a)(3) of this section, a covered health care provider must obtain the individual's consent, in accordance with this section, prior to using or disclosing protected health information to carry out treatment, payment, or health care operations.

(2) A covered health care provider may, without consent, use or disclose protected health information to carry out treatment, payment, or health care operations, if:

(i) The covered health care provider has an indirect treatment relationship with the individual; or

(ii) The covered health care provider created or received the protected health information in the course of providing health care to an individual who is an inmate.

(3)(i) A covered health care provider may, without prior consent, use or disclose protected health information created or received under paragraph (a)(3)(i)(A)–(C) of this section to carry out treatment, payment, or health care operations:

(A) In emergency treatment situations, if the covered health care provider attempts to obtain such consent as soon as reasonably practicable after the delivery of such treatment;

(B) If the covered health care provider is required by law to treat the individual, and the covered health care provider attempts to obtain such consent but is unable to obtain such consent; or

(C) If a covered health care provider attempts to obtain such consent from the individual but is unable to obtain such consent due to substantial barriers to communicating with the individual, and the covered health care provider determines, in the exercise of professional judgment, that the individual's consent to receive treatment is clearly inferred from the circumstances.

(ii) A covered health care provider that fails to obtain such consent in accordance with paragraph (a)(3)(i) of this section must document its attempt to obtain consent and the reason why consent was not obtained.

(4) If a covered entity is not required to obtain consent by paragraph (a)(1) of this section, it may obtain an individual's consent for the covered entity's own use or disclosure of protected health information to carry out treatment, payment, or health care operations, provided that such consent meets the requirements of this section.

(5) Except as provided in paragraph (f)(1) of this section, a consent obtained by a covered entity under this section is not effective to permit another covered entity to use or disclose protected health information.

(b) *Implementation specifications: General requirements.* (1) A covered health care provider may condition treatment on the provision by the individual of a consent under this section.

(2) A health plan may condition enrollment in the health plan on the provision by the individual of a consent under this section sought in conjunction with such enrollment.

(3) A consent under this section may not be combined in a single document with the notice required by § 164.520.

(4)(i) A consent for use or disclosure may be combined with other types of written legal permission from the individual (*e.g.*, an informed consent for treatment or a consent to assignment of benefits), if the consent under this section:

(A) Is visually and organizationally separate from such other written legal permission; and

(B) Is separately signed by the individual and dated.

(ii) A consent for use or disclosure may be combined with a research authorization under § 164.508(f).

(5) An individual may revoke a consent under this section at any time, except to the extent that the covered entity has taken action in reliance thereon. Such revocation must be in writing.

(6) A covered entity must document and retain any signed consent under this section as required by § 164.530(j).

(c) *Implementation specifications: Content requirements.* A consent under this section must be in plain language and:

(1) Inform the individual that protected health information may be used and disclosed to carry out treatment, payment, or health care operations;

(2) Refer the individual to the notice required by § 164.520 for a more complete description of such uses and disclosures and state that the individual has the right to review the notice prior to signing the consent;

(3) If the covered entity has reserved the right to change its privacy practices that are described in the notice in accordance with § 164.520(b)(1)(v)(C), state that the terms of its notice may change and describe how the individual may obtain a revised notice;

(4) State that:

(i) The individual has the right to request that the covered entity restrict how protected health information is used or disclosed to carry out treatment, payment, or health care operations;

(ii) The covered entity is not required to agree to requested restrictions; and

(iii) If the covered entity agrees to a requested restriction, the restriction is binding on the covered entity;

(5) State that the individual has the right to revoke the consent in writing, except to the extent that the covered entity has taken action in reliance thereon; and

(6) Be signed by the individual and dated.

(d) *Implementation specifications: Defective consents.* There is no consent under this section, if the document submitted has any of the following defects:

(1) The consent lacks an element required by paragraph (c) of this section, as applicable; or

(2) The consent has been revoked in accordance with paragraph (b)(5) of this section.

(e) *Standard: Resolving conflicting consents and authorizations.* (1) If a covered entity has obtained a consent under this section and receives any other authorization or written legal permission from the individual for a disclosure of protected health information to carry out treatment, payment, or health care operations, the covered entity may disclose such protected health information only in accordance with the more restrictive consent, authorization, or other written legal permission from the individual.

(2) A covered entity may attempt to resolve a conflict between a consent and an authorization or other written legal permission from the individual described in paragraph (e)(1) of this section by:

(i) Obtaining a new consent from the individual under this section for the disclosure to carry out treatment, payment, or health care operations; or

(ii) Communicating orally or in writing with the individual in order to determine the individual's preference in resolving the conflict. The covered entity must document the individual's preference and may only disclose protected health information in accordance with the individual's preference.

(f)(1) *Standard: Joint consents.* Covered entities that participate in an organized health care arrangement and that have a joint notice under § 164.520(d) may comply with this section by a joint consent.

(2) *Implementation specifications: Requirements for joint consents.* (i) A joint consent must:

(A) Include the name or other specific identification of the covered entities, or classes of covered entities, to which the joint consent applies; and

(B) Meet the requirements of this section, except that the statements required by this section may be altered to reflect the fact that the consent covers more than one covered entity.

(ii) If an individual revokes a joint consent, the covered entity that receives the revocation must inform the other entities covered by the joint consent of the revocation as soon as practicable.

EFFECTIVE DATE NOTE: At 67 FR 53268, Aug. 14, 2002, § 164.506 was revised, effective Oct. 15,

2002. For the convenience of the user, the revised text is set forth as follows:

**§ 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.**

(a) *Standard: Permitted uses and disclosures.* Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b) *Standard: Consent for uses and disclosures permitted.* (1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under § 164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.

(c) *Implementation specifications: Treatment, payment, or health care operations.*

(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) A covered entity may disclose protected health information for treatment activities of a health care provider.

(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.

(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance.

(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

**§ 164.508 Uses and disclosures for which an authorization is required.**

(a) *Standard: Authorizations for uses and disclosures.* (1) *Authorization required: General rule.* Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization.

(2) *Authorization required: psychotherapy notes.* Notwithstanding any other provision of this subpart, other than transition provisions provided for in § 164.532, a covered entity must obtain an authorization for any use or disclosure of psychotherapy notes, except:

(i) To carry out the following treatment, payment, or health care operations, consistent with consent requirements in § 164.506:

(A) Use by originator of the psychotherapy notes for treatment;

(B) Use or disclosure by the covered entity in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

(C) Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual; and

(ii) A use or disclosure that is required by § 164.502(a)(2)(ii) or permitted by § 164.512(a); § 164.512(d) with respect to the oversight of the originator of the psychotherapy notes; § 164.512(g)(1); or § 164.512(j)(1)(i).

(b) *Implementation specifications: General requirements*—(1) *Valid authorizations.*

(i) A valid authorization is a document that contains the elements listed in paragraph (c) and, as applicable, paragraph (d), (e), or (f) of this section.

(ii) A valid authorization may contain elements or information in addition to the elements required by this section, provided that such additional

*notification purposes.* (1) *Permitted uses and disclosures.* (i) A covered entity may, in accordance with paragraphs (b)(2) or (3) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.

(ii) A covered entity may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. Any such use or disclosure of protected health information for such notification purposes must be in accordance with paragraphs (b)(2), (3), or (4) of this section, as applicable.

(2) *Uses and disclosures with the individual present.* If the individual is present for, or otherwise available prior to, a use or disclosure permitted by paragraph (b)(1) of this section and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it:

(i) Obtains the individual's agreement;

(ii) Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or

(iii) Reasonably infers from the circumstances, based the exercise of professional judgment, that the individual does not object to the disclosure.

(3) *Limited uses and disclosures when the individual is not present.* If the individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

(4) *Use and disclosures for disaster relief purposes.* A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

EFFECTIVE DATE NOTE: At 67 FR 53270, Aug. 14, 2002, in §164.510 revise the first sentence of the introductory text, and remove the word "for" from paragraph (b)(3), effective Oct. 15, 2002. For the convenience of the user, the revised text is set forth as follows:

**§ 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.**

A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. * * *

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**§ 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.**

A covered entity may use or disclose protected health information without the written consent or authorization of the individual as described in §§164.506 and 164.508, respectively, or the opportunity for the individual to agree or object as described in §164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform

the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) *Standard: Uses and disclosures required by law.* (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) *Standard: uses and disclosures for public health activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration:

(A) To report adverse events (or similar reports with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations if the disclosure is made to the person required or directed to report such information to the Food and Drug Administration;

(B) To track products if the disclosure is made to a person required or directed by the Food and Drug Administration to track the product;

(C) To enable product recalls, repairs, or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems); or

(D) To conduct post marketing surveillance to comply with requirements or at the direction of the Food and Drug Administration;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if:

(A) The covered entity is a covered health care provider who is a member of the workforce of such employer or who provides a health care to the individual at the request of the employer:

(*1*) To conduct an evaluation relating to medical surveillance of the workplace; or

(*2*) To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance;

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(*1*) By giving a copy of the notice to the individual at the time the health care is provided; or

(*2*) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at

the location where the health care is provided.

(2) *Permitted uses.* If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) *Standard: Disclosures about victims of abuse, neglect or domestic violence.* (1) *Permitted disclosures.* Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) *Informing the individual.* A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) *Standard: Uses and disclosures for health oversight activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) *Exception to health oversight activities.* For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) *Joint activities or investigations.* Nothwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in

conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) *Permitted uses.* If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) *Standard: Disclosures for judicial and administrative proceedings.*

(1) *Permitted disclosures.* A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(*1*) No objections were filed; or

(*2*) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Nothwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this

section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements of paragraph (e)(1)(iv) of this section.

(2) *Other uses and disclosures under this section.* The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

(f) *Standard: Disclosures for law enforcement purposes.* A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) *Permitted disclosures: Pursuant to process and as otherwise required by law.* A covered entity may disclose protected health information:

(i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section; or

(ii) In compliance with and as limited by the relevant requirements of:

(A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

(B) A grand jury subpoena; or

(C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

(*1*) The information sought is relevant and material to a legitimate law enforcement inquiry;

(*2*) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(*3*) De-identified information could not reasonably be used.

(2) *Permitted disclosures: Limited information for identification and location purposes.* Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

(i) The covered entity may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(ii) Except as permitted by paragraph (f)(2)(i) of this section, the covered entity may not disclose for the purposes of identification or location under paragraph (f)(2) of this section any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

(3) *Permitted disclosure: Victims of a crime.* Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(ii) The individual agrees to the disclosure; or

(iii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

(B) The law enforcement official represents that immediate law enforcement activity that depends upon the

disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(4) *Permitted disclosure: Decedents.* A covered entity may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if the covered entity has a suspicion that such death may have resulted from criminal conduct.

(5) *Permitted disclosure: Crime on premises.* A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

(6) *Permitted disclosure: Reporting crime in emergencies.* (i) A covered health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(A) The commission and nature of a crime;

(B) The location of such crime or of the victim(s) of such crime; and

(C) The identity, description, and location of the perpetrator of such crime.

(ii) If a covered health care provider believes that the medical emergency described in paragraph (f)(6)(i) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, paragraph (f)(6)(i) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to paragraph (c) of this section.

(g) *Standard: Uses and disclosures about decedents.* (1) *Coroners and medical examiners.* A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

(2) *Funeral directors.* A covered entity may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors carry out their duties, the covered entity may disclose the protected health information prior to, and in reasonable anticipation of, the individual's death.

(h) *Standard: Uses and disclosures for cadaveric organ, eye or tissue donation purposes.* A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(i) *Standard: Uses and disclosures for research purposes.* (1) *Permitted uses and disclosures.* A covered entity may use or disclose protected health information for research, regardless of the source of funding of the research, provided that:

(i) *Board approval of a waiver of authorization.* The covered entity obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization required by §164.508 for use or disclosure of protected health information has been approved by either:

(A) An Institutional Review Board (IRB), established in accordance with 7 CFR 1c.107, 10 CFR 745.107, 14 CFR 1230.107, 15 CFR 27.107, 16 CFR 1028.107, 21 CFR 56.107, 22 CFR 225.107, 24 CFR 60.107, 28 CFR 46.107, 32 CFR 219.107, 34 CFR 97.107, 38 CFR 16.107, 40 CFR 26.107, 45 CFR 46.107, 45 CFR 690.107, or 49 CFR 11.107; or

(B) A privacy board that:

(*1*) Has members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the individual's privacy rights and related interests;

(2) Includes at least one member who is not affiliated with the covered entity, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and

(3) Does not have any member participating in a review of any project in which the member has a conflict of interest.

(ii) *Reviews preparatory to research.* The covered entity obtains from the researcher representations that:

(A) Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research;

(B) No protected health information is to be removed from the covered entity by the researcher in the course of the review; and

(C) The protected health information for which use or access is sought is necessary for the research purposes.

(iii) *Research on decedent's information.* The covered entity obtains from the researcher:

(A) Representation that the use or disclosure is sought is solely for research on the protected health information of decedents;

(B) Documentation, at the request of the covered entity, of the death of such individuals; and

(C) Representation that the protected health information for which use or disclosure is sought is necessary for the research purposes.

(2) *Documentation of waiver approval.* For a use or disclosure to be permitted based on documentation of approval of an alteration or waiver, under paragraph (i)(1)(i) of this section, the documentation must include all of the following:

(i) *Identification and date of action.* A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;

(ii) *Waiver criteria.* A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:

(A) The use or disclosure of protected health information involves no more than minimal risk to the individuals;

(B) The alteration or waiver will not adversely affect the privacy rights and the welfare of the individuals;

(C) The research could not practicably be conducted without the alteration or waiver;

(D) The research could not practicably be conducted without access to and use of the protected health information;

(E) The privacy risks to individuals whose protected health information is to be used or disclosed are reasonable in relation to the anticipated benefits if any to the individuals, and the importance of the knowledge that may reasonably be expected to result from the research;

(F) There is an adequate plan to protect the identifiers from improper use and disclosure;

(G) There is an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law; and

(H) There are adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart.

(iii) *Protected health information needed.* A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or privacy board has determined, pursuant to paragraph (i)(2)(ii)(D) of this section;

(iv) *Review and approval procedures.* A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:

(A) An IRB must follow the requirements of the Common Rule, including the normal review procedures (7 CFR 1c.108(b), 10 CFR 745.108(b), 14 CFR 1230.108(b), 15 CFR 27.108(b), 16 CFR 1028.108(b), 21 CFR 56.108(b), 22 CFR 225.108(b), 24 CFR 60.108(b), 28 CFR 46.108(b), 32 CFR 219.108(b), 34 CFR 97.108(b), 38 CFR 16.108(b), 40 CFR

26.108(b), 45 CFR 46.108(b), 45 CFR 690.108(b), or 49 CFR 11.108(b)) or the expedited review procedures (7 CFR 1c.110, 10 CFR 745.110, 14 CFR 1230.110, 15 CFR 27.110, 16 CFR 1028.110, 21 CFR 56.110, 22 CFR 225.110, 24 CFR 60.110, 28 CFR 46.110, 32 CFR 219.110, 34 CFR 97.110, 38 CFR 16.110, 40 CFR 26.110, 45 CFR 46.110, 45 CFR 690.110, or 49 CFR 11.110);

(B) A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, including at least one member who satisfies the criterion stated in paragraph (i)(1)(i)(B)(2) of this section, and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an expedited review procedure in accordance with paragraph (i)(2)(iv)(C) of this section;

(C) A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the protected health information for which use or disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more members of the privacy board as designated by the chair; and

(v) *Required signature.* The documentation of the alteration or waiver of authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the privacy board, as applicable.

(j) *Standard: Uses and disclosures to avert a serious threat to health or safety.* (1) *Permitted disclosures.* A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in §164.501.

(2) *Use or disclosure not permitted.* A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

(3) *Limit on information that may be disclosed.* A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i) of this section.

(4) *Presumption of good faith belief.* A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

(k) *Standard: Uses and disclosures for specialized government functions.* (1) *Military and veterans activities.* (i) *Armed Forces personnel.* A covered entity may use and disclose the protected health information of individuals who are

Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the FEDERAL REGISTER the following information:

(A) Appropriate military command authorities; and

(B) The purposes for which the protected health information may be used or disclosed.

(ii) *Separation or discharge from military service.* A covered entity that is a component of the Departments of Defense or Transportation may disclose to the Department of Veterans Affairs (DVA) the protected health information of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

(iii) *Veterans.* A covered entity that is a component of the Department of Veterans Affairs may use and disclose protected health information to components of the Department that determine eligibility for or entitlement to, or that provide, benefits under the laws administered by the Secretary of Veterans Affairs.

(iv) *Foreign military personnel.* A covered entity may use and disclose the protected health information of individuals who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for Armed Forces personnel under the notice published in the FEDERAL REGISTER pursuant to paragraph (k)(1)(i) of this section.

(2) *National security and intelligence activities.* A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, *et seq.*) and implementing authority (*e.g.*, Executive Order 12333).

(3) *Protective services for the President and others.* A covered entity may disclose protected health information to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or to for the conduct of investigations authorized by 18 U.S.C. 871 and 879.

(4) *Medical suitability determinations.* A covered entity that is a component of the Department of State may use protected health information to make medical suitability determinations and may disclose whether or not the individual was determined to be medically suitable to the officials in the Department of State who need access to such information for the following purposes:

(i) For the purpose of a required security clearance conducted pursuant to Executive Orders 10450 and 12698;

(ii) As necessary to determine worldwide availability or availability for mandatory service abroad under sections 101(a)(4) and 504 of the Foreign Service Act; or

(iii) For a family to accompany a Foreign Service member abroad, consistent with section 101(b)(5) and 904 of the Foreign Service Act.

(5) *Correctional institutions and other law enforcement custodial situations.* (i) *Permitted disclosures.* A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

(B) The health and safety of such individual or other inmates;

(C) The health and safety of the officers or employees of or others at the correctional institution;

(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;

(E) Law enforcement on the premises of the correctional institution; and

(F) The administration and maintenance of the safety, security, and good order of the correctional institution.

(ii) *Permitted uses.* A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.

(iii) *No application after release.* For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

(6) *Covered entities that are government programs providing public benefits.* (i) A health plan that is a government program providing public benefits may disclose protected health information relating to eligibility for or enrollment in the health plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

(l) *Standard: Disclosures for workers' compensation.* A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

EFFECTIVE DATE NOTE: At 67 FR 53270, Aug. 14, 2002, § 164.512 was amended by revising the section heading and the first sentence of the introductory text; revising paragraph (b)(1)(iii); in paragraph (b)(1)(v)(A) removing the word "a" before the word "health"; adding the word "and" after the semicolon at the end of paragraph (b)(1)(v)(C); redesignating paragraphs (f)(3)(ii) and (iii) as (f)(3)(i) and (ii); in the second sentence of paragraph (g)(2) add the word "to" after the word "directors"; in paragraph (i)(1)(iii)(A) removing the word "is" after the word "disclosure"; revising paragraph (i)(2)(ii); in paragraph (i)(2)(iii) remove "(i)(2)(ii)(D)" and add in its place "(i)(2)(ii)(C)", effective Oct. 15, 2002. For the convenience of the user, the revised text is set forth as follows:

**§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.**

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. * * *

* * * * *

(b) *Standard: uses and disclosures for public health activities.*

(1) *Permitted disclosures.* * * *

(iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

(A) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

(B) To track FDA-regulated products;

(C) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback); or

(D) To conduct post marketing surveillance;

* * * * *

(i) *Standard: Uses and disclosures for research purposes.* * * *

(2) *Documentation of waiver approval.* * * *

(ii) *Waiver criteria.* A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:

(A) The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements;

(*1*) An adequate plan to protect the identifiers from improper use and disclosure;

(*2*) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and

(*3*) Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by this subpart;

(B) The research could not practicably be conducted without the waiver or alteration; and

(C) The research could not practicably be conducted without access to and use of the protected health information.

* * * * *

**§ 164.514 Other requirements relating to uses and disclosures of protected health information.**

(a) *Standard: de-identification of protected health information.* Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

(b) *Implementation specifications: requirements for de-identification of protected health information.* A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination; or

(2)(i) The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(*1*) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(*2*) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers;

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code; and

(ii) The covered entity does not have actual knowledge that the information could be used alone or in combination

# STATE MEDICAL BOARD OF OHIO
# FORMAL ACTION REPORT – March 2007
**Revised April 30, 2007**

Prepared by: Sallie Debolt, Executive Staff Attorney

Date: April 17, 2007

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The State Medical Board of Ohio did not meet in February 2007 due to weather conditions throughout the state. Listed below is a summary of the disciplinary actions taken or initiated by the State Medical Board of Ohio in March 2007, previously unreported formal actions, and an update of Board matters pending in courts as of the date of this document.

## PRE-HEARING SUSPENSION

**EBNER, Gregory Lee (DO #34-003080) Cincinnati, OH**

Pursuant to Section 3719.121(C), O.R.C., doctor's medical license immediately suspended based on doctor's plea of guilty in U.S. District Court, Southern District of Ohio, to one felony count of Money Laundering and one felony count of Structuring Monetary Transactions, arising from activities involving illicit concealing of monies obtained as a result of the illegal distribution of Schedule III and IV controlled substances. Suspension effective 3/14/07; Notice mailed 3/15/07. (*See also:* Citations/Proposed Denials *below*)

## CITATIONS & PROPOSED DENIALS

**BHAMA, Savitri (MD applicant) - Clinton Township, MI**

Proposal to deny application for medical license based on applicant allegedly having made false, fraudulent, deceptive, or misleading statements on licensure application and failing to furnish satisfactory proof of good moral character. Notice of opportunity for hearing mailed 3/15/07.

**BLAZEY, Kristine Marie (LMT applicant) – Toledo, OH**

Proposal to deny application for massage therapy license based on applicant's plea of guilty or finding of guilt of one count of Attempt to Commit Forgery and alleged false, fraudulent, deceptive, or misleading statements in attempting to secure a massage therapy certificate to practice. Notice of opportunity for hearing mailed 3/15/07.

**CALIGARIS, Joseph Thayer (MD #35-050658) – Cincinnati, OH (Revised 4/30/07)**

Notice of hearing scheduled for 2/8/07, pursuant to doctor's 12/20/02 consent agreement with the Board, for the purpose of determining the terms, conditions, or limitations, if any, that should be imposed upon the doctor based upon the recommendations of the Colorado Physicians Effectiveness Program. Notice of hearing mailed 12/14/06.

**EBNER, Gregory Lee (DO #34-003080) Cincinnati, OH**

Based on doctor's having pled guilty in U.S. District Court, Southern District of Ohio, to one felony count of Money Laundering and one felony count of Structuring Monetary Transactions, the conduct implicated being doctor's concealing of monies obtained as a result of the illegal distribution of Schedule III and IV controlled substances. Notice of opportunity for hearing mailed 3/15/07. (*See also*: Pre-Hearing Suspension *above*)

**HUMPHREY, Dale Anthony, Jr. (LMT applicant) – Dayton, OH**

Proposal to deny application for massage therapy license based on applicant having been convicted of one felony count of Conspiracy to Commit Wire Fraud in the U.S. District Court for the Middle District of Florida. Notice of opportunity for hearing mailed 3/15/07.

**KENNEN, James Michael (DO #34-004546) – Cleveland, OH**

Proposal to deny request for reinstatement of doctor's revoked medical license based on doctor's alleged impairment of ability to practice according to acceptable and prevailing standards of care due to relapse on alcohol. Notice of Opportunity for hearing mailed 3/15/07.

**KNOX, Robert Alan (DPM #36-002382) – Columbiana, OH**

Based on doctor's plea of guilty and judicial finding of guilt in U.S. District Court, Southern District of West Virginia, to one felony count of a distribution of hydrocodone, a Schedule III controlled substance, without lawful authorization; prior actions by the West Virginia board to revoke doctor's West Virginia license and the Virginia board to suspend doctor's privilege to renew licensure in that state; and exclusion from participating in Medicare, Medicaid, and all federal health care programs. Notice of opportunity for hearing mailed 3/15/07.

**LONTOC, Manolito Manabo (MD #35-038534) – South Point, OH**

Based on doctor's alleged failure to maintain records of controlled substances ordered and received and controlled substances administered or dispensed, failure to cooperate in a Board investigation, and making a false, fraudulent, deceptive, or misleading statement in relation to the practice of medicine and surgery and/or in securing or attempting to secure a medical license. Notice of opportunity for hearing mailed 3/15/07.

**MAI, David Chi (DPM Training Certificate #59-000197) – Cleveland, OH**

Based on doctor having pled guilty to one felony count of Theft of Currency in the Circuit Court of Williamson County, Tennessee and the doctor's alleged failure to furnish satisfactory proof of good moral character due to the felony conviction and alleged previous dismissal from a podiatric medical school due to dishonesty. Notice of opportunity for hearing mailed 3/15/07.

**QUIGLEY, Jack B. (MD #35-051017) – Flagstaff, AZ**
**a.k.a. John B. Quigley**

Based on prior actions by Arizona's board, which limited and restricted doctor's Arizona medical practice and reprimanded the doctor, with the underlying basis including that the doctor practiced below the standard of care with respect to treatment provided to one patient. Notice of opportunity for hearing mailed 3/15/07.

**SANDHU, Gurpal Singh (MD #-35-086710) – Oakland, CA**

Based on doctor's alleged failure to cooperate in a Board investigation of prior action taken by Idaho's board. Notice of opportunity for hearing mailed 3/15/07.

**WRIGHT, Jamey D. (MD Telemedicine applicant) – Columbia, MO**

Proposal to deny application for telemedicine license based on alleged false, fraudulent, deceptive, or misleading statements on doctor's Ohio and Iowa licensure applications and on

doctor's failure to submit satisfactory proof of good moral character. Notice of opportunity for hearing mailed 3/15/07.

## FINAL DISCIPLINARY ORDERS

**ACKERMAN, Andrew Paul Lincoln (Massage Therapy applicant) – Columbus, OH**

Application for massage therapy license denied. Based on applicant's felony conviction for receiving stolen property. Order effective 3/14/07. (Journal Entry – no hearing requested)

**ADKINS, Paula Clark (MD #35-072775) – Pinehurst, NC**

Reinstatement of medical license granted, with doctor reprimanded, and probationary terms, conditions, and limitations imposed to monitor doctor's practice for a period of at least four years. Based on doctor's impairment and failure to provide full information to an evaluating physician and in response to Board interrogatories, and in recognition that doctor, who resides in North Carolina, is monitored pursuant to an order of the North Carolina board. Order effective 3/16/07.

**CREPS, Phillip L. (DO #34-005726) – Saginaw, MI**

Doctor reprimanded, reporting requirements established, and all terms and conditions of the 2/8/06 Board Order to remain in effect. Based on prior action by Missouri medical board, which reprimanded doctor's Missouri license. Order effective 4/11/07.

**DAVIS, Mark Allen (LMT #33-004464) – Mansfield, OH**

Massage therapy license permanently revoked. Based on massage therapist having been found guilty of one felony count of Practice of Medicine or Surgery without a Certificate, one felony count of Engaging in a Pattern of Corrupt Activity, two felony counts of Forgery, and one felony count of Theft by Deception. Order effective 3/16/07.

**FINKS, Robert James (Massage Therapy applicant) – Newark, OH**

Application for massage therapy license denied. Based on applicant having been convicted of two felony counts of receiving stolen property. Order effective 3/14/07. (Journal Entry – no hearing requested)

**GEMMER, Thomas Leon (PA #50-000511) – Port Clinton, OH**

Physician assistant license revoked based on prior action by Indiana's board revoking Indiana license due, in part, to physician assistant writing and signing more than 200 prescriptions using an invalid DEA number and writing and signing over 300 prescriptions for controlled substances despite the lack of prescriptive authority for Indiana physician assistants. Order effective 3/16/07.

**MEYER, Jeffrey Vaughn (MD #35-088466) – Columbus, OH**

Revocation of medical license stayed, with medical license suspended for at least 90 days from date of summary suspension on 11/8/06; interim monitoring conditions and conditions for reinstatement or restoration imposed; subsequent probationary terms, conditions, and limitations for at least five years established. Based on doctor's impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances and violation of conditions of limitation imposed on doctor's license by 8/9/06 Consent Agreement. Order effective 3/16/07.

**PARKS, Alan Joseph (MD #35-054686) – Columbus, OH**

Medical license suspended for 180 days, with suspension stayed subject to probationary terms, conditions, and limitations imposed to monitor doctor's practice for at least three years. Based on doctor's failure to conform to minimal standards of care with respect to treatment of three specified patients. Order effective 3/16/07.

**PHEN, Lovsho (MD #35-055007) – Portola, CA**

Permanent revocation of medical license stayed, with license suspended for at least one year; conditions for reinstatement and subsequent probationary terms, conditions, and limitations for at least three years established. Based on doctor's guilty plea to six first degree misdemeanor counts of Attempted Illegal Processing of Drug Documents pertaining to false or forged prescriptions for a Schedule IV controlled substance. Order effective 4/11/07.

**ROSENBERG, Mark Robert (MD #35-066727) – Elisville, MO** (Revised summary)

Permanent revocation of medical license stayed, with license suspended for at least one year; conditions for reinstatement and subsequent probationary terms, conditions, and limitations for at least five years established. Based on doctor's having been found guilty of two federal misdemeanor counts of knowingly receiving stolen property (money) with the intent to convert the money to his own use. Order effective 12/1/06.

**SCHRAMM, Arthur Richard (MD #35-031253) – Dayton, OH**

Medical license permanently revoked. Based on doctor's violation of AMA Principles of Medical Ethics, failure to maintain minimum standards of care, and failure to maintain medical records to accurately reflect controlled substance prescriptions in the care of three specified patients. Order effective 3/16/07.

**SMITH, Albert W., III (MD #35-031140) – Bowling Green, OH**

Permanent revocation of medical license stayed, with license suspended for at least two years; conditions for reinstatement or restoration established; subsequent probationary terms, conditions, and limitations for at least three years established. Based on doctor's failure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities of treatment; failure to maintain minimal standards of care applicable to selection or administration of drugs; failure to conform to minimal standards of care; and failure to complete and maintain accurate medical records reflecting utilization of controlled substances with respect to treatment rendered to one specified patient. Order effective 4/11/07.

## INTERIM AGREEMENT

**VOLKMAN, Paul H. (MD #35-070722) – Chillicothe, OH (Previously unreported)**

By Interim Agreement effective 5/25/06, doctor agreed not to practice medicine and surgery in Ohio in any form until allegations set forth in the 3/8/06 notice of opportunity for hearing have been fully resolved.

## CONSENT AGREEMENTS

**DAY, Richard Graham (MD #35-061831) – Cambridge, OH**

Medical license reinstated subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having been deemed capable of practicing according to acceptable and prevailing standards of care so long as certain treatment and monitoring conditions are in place. Agreement effective 3/14/07; agreement to remain in effect for at least five years prior to any request for termination.

**DIAMANTIS, Nicholas Constantine (MD #35-069292) – Lakewood, OH (Previously unreported)**

Medical licensed suspended for 30 days; subsequent probationary terms, conditions, and limitations for at least five years established. Based on doctor's admissions related to the performance of dental procedures without holding a license to practice dentistry. Agreement effective 9/30/04.

**EATON, Lynne Antoinette (MD #35-060149) – Columbus, OH**

Consent Agreement dated 10/15/04 terminated. Medical license suspended for at least 90 days; interim monitoring conditions and conditions for reinstatement established, including requirement that doctor enter into subsequent consent agreement incorporating probationary terms, conditions, and limitations to monitor practice. Based on doctor's admitted non-compliance with terms of the 10/15/04 Consent Agreement and relapse on Percocet, for which doctor has sought treatment through a Board-approved provider. Agreement effective 3/14/07.

**GROSS, Carey Kathleen (DO Training Certificate #58-002297) – Cincinnati, OH**

Probationary terms, conditions, and limitation established. Based on doctor's admitted history of alcohol dependence, for which doctor has sought treatment through a Board-approved provider, and diagnosis of atypical depression and doctor having been deemed capable of practicing according to acceptable and prevailing standards of care so long as certain treatment and monitoring conditions are in place. Agreement effective 3/14/07; agreement to remain in effect for at least five years prior to any request for termination.

**HALL, Adam Patrick (DO #34-008707) – Greenwood, MO**

Medical license reinstated subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having been deemed capable of practicing according to acceptable and prevailing standards of care so long as certain treatment and monitoring conditions are in place. Agreement effective 3/14/07; agreement to remain in effect for at least five years prior to any request for termination.

**HETMAN, Ronald Carl (DPM #36-001421) – Centerville, OH**

Medical license reinstated subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having fulfilled reinstatement conditions as established in 2/8/06 Consent Agreement. Agreement effective 3/14/07; agreement to remain in effect for at least five years prior to any request for termination.

**NORTH, Phillip Thiele (MD #35-057152) – Columbus, OH**

Medical license reinstated subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having met the conditions for reinstatement specified in the

10/12/06 Consent Agreement. Agreement effective 3/14/07; agreement to remain in effect for at least five years prior to any request for termination.

**RISE, Leroy P. (MD #35-088474) – Baltimore, OH**

Consent Agreement dated 12/14/05 terminated. Revocation of medical license stayed, and suspended for at least 90 days; interim monitoring conditions and conditions for reinstatement established, including requirement that doctor enter into subsequent consent agreement incorporating probationary terms, conditions, and limitations to monitor practice. Based on doctor's admitted relapse on alcohol, for which doctor sought evaluation and treatment recommendations from a Board-approved provider. Agreement effective 3/14/07.

**SCHLOTTERER, William L. (DO #34-003224) – Sandusky, OH**

Medical license suspended for at least 90 days; interim monitoring conditions and conditions for reinstatement established, including requirement that doctor enter into subsequent consent agreement incorporating probationary terms, conditions, and limitations to monitor practice. Based on diagnosis of alcohol dependence, for which doctor has sought treatment through a Board-approved provider, and doctor's inability to practice according to acceptable and prevailing standards of care due to use or abuse of alcohol. Agreement effective 3/14/07.

**SPIESS, Patricia Ann (MD #35-049816) – Wooster, OH**

Medical license restored subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having been deemed capable of practicing according to acceptable and prevailing standards of care so long as certain treatment and monitoring conditions are in place. Agreement effective 3/14/07; agreement to remain in effect for at least two years prior to any request for termination.

**THOMAS, Gregory Michael (MD #35-048215) – Toledo, OH**

Permanent revocation of medical license stayed, with medical license suspended for at least two years; conditions for reinstatement and subsequent probationary terms, conditions, and limitations for at least five years established. Based on doctor having pled guilty to and being found guilty of two felony counts of Mail Fraud. Order effective 4/28/07; agreement to remain in effect for at least five years following reinstatement or restoration of doctor's medical license, prior to any request for termination.

**TURNER, Ross Putnam (DO Training Certificate #58-001438) – Columbus, OH**

Osteopathic training certificate suspended for at least 180 days; interim monitoring conditions and conditions for reinstatement established, including requirement that doctor enter into subsequent consent agreement incorporating probationary terms, conditions, and limitations to monitor practice. Based on doctor's admitted inability to practice according to acceptable and prevailing standards of care due to habitual or excessive use or abuse of drugs, for which doctor has sought treatment through a Board-approved provider. Agreement effective 3/14/07.

**WHALEN, John Kevin (MD #35-073148) – Covington, KY**

Medical license restored subject to probationary terms, conditions, and limitations imposed to monitor practice based on doctor having been deemed capable of practice according to acceptable and prevailing standards of care, so long as certain treatment and monitoring conditions are in place. Agreement effective 3/14/07; agreement to remain in effect for at least two years prior to any request for termination.

**WHITLOCK, Randall Gregory, Jr. (PA #50-001262) – Cincinnati, OH**

Physician assistant license suspended for at least 180 days; interim monitoring conditions and conditions for reinstatement established, including requirement that physician assistant enter into subsequent consent agreement incorporating probationary terms, conditions, and limitations to monitor practice. Based on physician assistant's admitted history of chemical dependency (alcohol, cocaine, and crack cocaine), for which physician assistant has sought treatment through a Board-approved provider, and physician assistant's admission of inability to practice according to acceptable and prevailing standards of care. Agreement effective 3/14/07.

## VOLUNTARY SURRENDERS/RETIREMENTS

**ISAAC, Gregory Lee (MD #35-048764) – Cincinnati, OH**

Board Order permanently revoking doctor's medical license as authorized by doctor in lieu of further investigation and/or formal disciplinary proceedings pursuant to Section 4731.22(B)(26), O.R.C. Effective 3/14/07.

**KAVOKLIS, Nicholas (DO #34-002457) – Youngstown, OH**

Doctor's permanent retirement form the practice of medicine accepted by Board in lieu of further investigation related to possible violation of Section 4731.22(B)(19), O.R.C. Effective 3/14/07.

## LICENSES REINSTATED/RESTORED

**KARASIK, Gregory (MD #35-068821) – Bellevue, OH**

Doctor's request for reinstatement of license approved by Board vote on 3/15/07 subject to probationary terms and conditions established in the 11/16/06 Consent Agreement. Reinstatement effective 3/15/07.

**O'BRIEN, Michael J. (DO #34-006651) – St. Clairsville, OH**

Doctor's request for restoration of license approved by Board vote on 3/15/07 subject to probationary terms and conditions established by 9/11/02 Board Order. Restoration effective 3/15/07.

## PROBATION COMPLETED

**CURTIS, Boyd D. (MD #35-059531) – Columbus, OH**

Doctor's request for release from the terms of the 3/14/02 Consent Agreement granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

**FLEMING, James Edward (MD #35-029707) – Bratenhal, OH**

Doctor's request for release from the terms of the 4/11/01 Board Order granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

**GOODEN, Timothy Alwyn (MD #35-048868) – Birmingham, Al**

Doctor's request for release from the terms of the 1/14/04 Board Order granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

**ISKANDER, Hany Maurice (MD #35-074030) – Bucyrus, OH**

Doctor's request for release from the terms of the 12/12/01 Board Order granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

**KLEINER, Laurence Irwin (MD #35-080822) – Dayton, OH**

Doctor's request for release from the terms of the 3/14/02 Consent Agreement granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

**MCCOY, Terrence Francis (MD #35-058974) – Cincinnati, OH**

Doctor's request for release from the terms of the 7/9/03 Board Order granted by Board vote on 3/15/07. Release from probation effective 1/30/07.

**MIKHAIL, Michael Sollman (MD #35-043221) – Elyria, OH**

Doctor's request for release from the terms of the 12/12/03 Board Order granted by Board vote on 3/15/07. Release from probation effective 3/15/07.

## PROBATION – MONITORING TERMS MODIFIED

**BLOCKER, David C. (MD #35-061188) Centerville, OH (Previously unreported)**

Doctor's request to remove restriction on performing, reviewing, or interpreting ultrasounds or CT scans granted by Board vote on 12/13/06.

**BIERER, Craig Lindsey (DO #34-008396) – Cuyahoga Falls, OH**

Doctor's request to discontinue required saliva testing and OPHP advocacy agreement approved by Board vote on 3/15/07.

**BRIGGS, Jeffrey Allen (MD #35-044176) – Powell, OH**

Doctor's request to reduce required drug screens to twice a month approved by Board vote on 3/15/07.

**CESTONE, Patrick Brian, Jr. (MD #35-070978) – Youngstown, OH**

Doctor's request to reduce required drug screens to twice per month, personal appearances to every six months, and alcohol and drug rehabilitation meetings to two per week with a minimum of 10 per month approved by Board vote on 3/15/07.

**DANIACHEW, Anthony Emmanuel (MD #35-083935) – Northfield Center, OH**

Doctor's proposed practice plan whereby doctor will travel to different physician offices to review patient medical records for use in various projects and studies approved by Board vote on 3/15/07.

**DIAMANTIS, Nicholas Constantine (MD #35-069292) – Lakewood, OH**

Doctor's request to reduce required personal appearances to once per year granted by Board vote on 3/15/07.

**GIORDANO, Stephen Robert (DO Training Certificate #58-001345) – Westlake, OH**

Doctor's request to reduce required personal appearances to every six months and drug screens to twice per month approved by Board vote on 3/15/07.

**HOPKINS, Jordan Eric (MD #36-084936) – Gainesville, FL**

Doctor's request to reduce required personal appearances to annually approved by Board vote on 3/15/07.

**KIRKLAND, Jeanne Marie (MD #36-045543) – Dayton, OH**

Doctor's request to reduce required personal appearances to annually approved by Board vote on 3/15/07.

**LEU, Melanie Lynne (MD #36-073229) – Vermillion, OH**

Doctor's request to reduce required psychiatrist sessions to every three months and psychologist sessions to every four weeks approved by Board vote on 3/15/07.

**MARSICO, Robert Edward, Jr. (MD #36-064913) – Akron, OH**

Doctor's request to discontinue required controlled substance logs approved by Board vote on 3/15/07.

**MCKEE, Kevin Dale (DO #34-006668) – Centerville, OH**

Doctor's request to reduce required psychological counseling to once a month, psychiatric sessions to every six months, and personal appearances to every six months approved by Board vote on 3/15/07.

**OGDEN, John Russell (MD #36-088934) – Columbus, OH**

Doctor's request to reduce required personal appearances to every six months approved by Board vote on 3/15/07.

**PRASAD, Kolli Mohan (MD #36-041939) – Boardman, OH**

Doctor's proposed practice plan for work as a radiologist in Iowa approved; monitoring physician approved and frequency and number of charts for review established by Board vote on 3/15/07.

**ROCKWOOD, John House (PA #50-001240) – Westerville, OH**

Physician assistant's request to reduce required drug screens to twice per month and personal appearances to every six months approved by Board vote on 3/15/07.

**RYAN, Jon Patrick (DO #34-008006) – Dayton, OH**

Monitoring physician approved and frequency and number of charts for review established by Board vote on 3/15/07.

**SPEARS, David Paul (DO #34-008838) – Chapmanville, WV**

Doctor's proposed practice plan for work in a hospital emergency department upon completion of residency in March 2007 approved by Board vote on 3/15/07.

**STURMI, James Edward (MD #35-060676) – Mount Vernon, OH**

Doctor's request to reduce required drug screens to twice per month and reduce required alcohol and drug rehabilitation meetings to three per week, with at least two Caduceus meetings each month, approved by Board vote on 3/15/07.

## COURT ACTION UPDATE

**ANSAR, Azber Azher (MD #35-078745) – Minneapolis, MN**

Notice of Appeal of Board's 1/10/07 Order filed by doctor with the Franklin County Court of Common Pleas on 2/14/07.

Motion for Stay of Board's 1/10/07 Order filed by doctor with the Franklin County Court of Common Pleas on or about 2/20/07.

**APPLEGATE, Gerald Brian (MD #35-065717) – Miami, FL**

Notice of Appeal of the 1/16/07 Judgment Entry of the Franklin County Court of Common Pleas, which had affirmed the Board's 6/14/06 Order, filed with the 10th District Court of Appeals on or about 1/26/07.

**COLTON, Danny Maurice (MD applicant) – Newtown, OH**

By Agreed Judgment Entry filed 2/16/07, the Franklin County Court of Common Pleas vacated the Board's 2/13/02 Notice of Opportunity for Hearing and 9/10/03 Order, and directed that the Board deem the doctor's 9/7/00 application for licensure as abandoned.

**CONIGLIO, Gerald Anthony (MD #35-047981) – Mt. Morris, NY**

By decision filed 3/5/07 and Judgment Entry filed 3/13/07, the Franklin County Court of Common Pleas affirmed the Board's 10/11/06 Order.

**DERAKHSHAN, Iraj (MD #35-037499) – Charleston, WV**

By Decision and Entry filed 3/9/07, the Franklin County Court of Common Pleas dismissed doctor's appeal of the Board's 1/11/06 Order.

**MOORE, John Pease, III (MD #35-069259) – Dayton, OH**

By decision filed 3/9/07 the Franklin County Court of Common Pleas affirmed the Board's 5/14/03 Order.

**PARKS, Alan Joseph (MD #35-054686) – Columbus, OH**

Notice of appeal of Board's 3/14/07 Order filed by doctor with the Franklin County Court of Common Pleas on or about 3/30/07.

**ROSENBERG, Mark Robert (MD #35-065727) – Elisville, MO**

Notice of Appeal of Board's 11/8/06 Order filed by doctor with the Franklin County Court of Common Pleas on 12/13/06.

## Non-Disciplinary Administrative Actions

### Final Board Order

**FEINGOLD, Alisa (LMT #33-008032) – Cleveland Heights, OH**

Application for restoration of certificate to practice massage therapy approved, provided applicant takes and passes the limited branch portion of the massage therapy exam within six months of 1/29/07. Based on applicant not have been engaged in the practice of massage therapy for more than two years. (Journal Entry – no hearing requested) Order effective 3/14/07. **(Non-disciplinary)**

**FRIDDLE, Ruth E. (LMT #33-004548) – Tiffin, OH**

Application for restoration of certificate to practice massage therapy approved, provided applicant takes and passes the limited branch portion of the massage therapy exam within six months of 1/29/07. Based on applicant not have been engaged in the practice of massage therapy for more than two years. (Journal Entry – no hearing requested) Order effective 3/14/07. **(Non-disciplinary)**

**HALTER, Jeffrey Michael (MD #35-089504) – Hilliard, OH**

Licensed granted by Board vote on 3/14/07. **(Non-disciplinary)**

**RICAURTE, Basma (MD applicant) – Cleveland, OH**

License granted by Board vote on 3/14/07. **(Non-disciplinary)**

### Voluntary Surrender

**FIERRA, Jeffrey James (MD #35-031774) – Cleveland, OH**

Doctor's permanent voluntary surrender of medical license accepted by Board vote on 3/14/07 in lieu of further compliance with the terms of the 2/4/05 Board Order; doctor ineligible for licensure in the future. Effective 3/14/07. **(Non-disciplinary)**

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**Please note that revocation and suspension Orders are not always effective immediately. If you have questions about effective dates or conditions governing a licensee's practice before a Board Order takes effect, please contact the office.**

**Ohio law permits appeal of a Board Order to the Franklin County Court of Common Pleas. Due to this possibility and the potential for a stay that might delay the imposition of a Board action, you may wish to contact us periodically to verify a given practitioner's licensure status.**

**Most current citation letters, Board Orders, consent agreements and voluntary surrenders or retirements are available on the Medical Board's website at http://med.ohio.gov/ under *"Licensee Profile and Status."* If you have questions or need additional details about specific cases, please contact Annette Jones at (614) 728-3686.**