MEDICAL MUTUAL OF OHIO,

Appellant,

v.

WILLIAM SCHLOTTERER, D.O.,

Appellee.

SUPREME COURT OF OHIO
CASE NO. 2008-0598

ON APPEAL FROM THE CUYAHOGA COUNTY COURT OF APPEALS, EIGHTH APPELLATE DISTRICT CASE NO. CA-07-089388

IN THE SUPREME COURT OF OHIO

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

Kirk J. Nahra [(admitted *pro hac vice*)]
Howard Anglin [(admitted *pro hac vice*)]
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 Plans*

TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* ii

I. SUMMARY OF ARGUMENT 1

II. ARGUMENT 4

A. Health Care Fraud Is A Substantial and Serious Problem. 4

B. The Court Underestimated the Compelling Interests in Favor of Disclosure in This Case. 8

1. The Court Failed to Consider the Interests of the Public, Patients and Third Parties, as Required by the *Biddle* Test. 10

2. The Court Improperly Belittled the Interests of Medical Mutual While Ignoring the Self Serving Position of Dr. Schlotterer. 14

C. The Court of Appeals Did Not Give Sufficient Consideration to the Necessity of the Patient Records to Medical Mutual's Investigation. 16

D. The Court Vastly Overstated the Privacy Interest at Stake in This Case. 18

1. The Court Failed to Take into Account the Position of Medical Mutual vis-à-vis the Patients Whose Records Were Sought. 19

2. The Court Improperly Discounted the Ability of a Protective Order to Prevent Disclosure of Confidential Patient Information to Parties other than Medical Mutual. 21

III. CONCLUSION 25

TABLE OF AUTHORITIES

CASES

Page

MISCELLANEOUS

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 the billings, Dr. Schlotterer agreed to cooperate with Medical Mutual investigation and provided the information sought with respect to certain of his patients. However, 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 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. Hospital*, 86 Ohio St. 3d 395, 402, 715 N.E.2d 518, 524 (Ohio 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—in conducting effective health care fraud investigations. 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 typical in insurance claim situations. 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, and the general public 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 their 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 scales, the Court of Appeals significantly overestimated the privacy interest at stake. This should have been easy case under the *Biddle* test. The *Biddle* test expressly provides for the disclosure of medical records to a third party who has no prior knowledge of, or access to, the medical records in question, when the public interest outweighs the patients' interest in privacy. Beyond this presumption that medical records can 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 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 the patients in this case vis-à-vis their insurer was almost zero. 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 this information to investigate Dr. Schlotterer's billing. Because of the low 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

A. Health Care Fraud Is A Substantial and Serious Problem.

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 [X] ("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 it is only going to get worse.

The enormous costs of health care fraud are borne by all Americans. Whether you have employer-sponsored health insurance or purchase your own insurance policy, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as

---

[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 ("FBI Report"), at [X], *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.

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*, The San Francisco Chronicle, April 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.

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 [X].

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.'"

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*, The Wall Street Journal, March 19, 2004, at A7. According to the Wall Street Journal, in the scheme employed by these clinics, "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 WCCP, ranking behind only public corruption and corporate fraud." FBI Report, at [X].[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 become uninsurable for both life and health insurance coverage; 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 Menn, *ID Theft Infects Medical Records*, Los Angeles Times, September 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

---

[4] Patient safety is not merely a speculative interest in this case. Shortly after the Court of Appeals 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.

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 this intimate and personal crime 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." *Id*. at [X]. 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.

B. <u>The Court Underestimated the Compelling Interests in Favor of Disclosure in This Case.</u>

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. of Ohio 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 of Oregon*, 298 Ore. 706, 720, 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 narrowly on the interests of Dr. Schlotterer's patients and completely ignored the compelling public interest in supporting health care fraud investigations and the interests of third parties, including insurers. *Medical Mutual of Ohio v. Schlotterer*, No. 89388, 2008 WL 94508 (Ohio App. 8 Dist., Jan. 10, 2008), at *4-*5. 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, and health care insurers such as Medical Mutual—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 Section [II.A], *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 and business as well as 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 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 provide for 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). Even more broadly, HIPAA regulations provide protections for health care providers that allow them to "disclose protected health information in the course of any judicial or administrative proceeding . . . [i]n response to an

---

[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.

order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order." 45 C.F.R. § 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 when it weighed the interests in favor of disclosure, as required by the *Biddle* test. *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 to which the insurer already has access the public interest in preventing health care fraud overwhelms the asserted privacy interest and the *Biddle* test compels disclosure of the records. *Cf. Ohio St. Medical Bd. v. Miller*, 44 Ohio St. 3d 136, 140, 540-41 N.E.2d 602, 606 (Ohio 1989) ("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 though 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"

---

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

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 belittled 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 the parties share a common interest in preventing health care fraud, ensuring the accurate diagnosis of illness and 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 Belittled 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 of Appeals 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, 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* Medical Mutual Mem., at 4. 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.*, *McGriff*, 109 Ohio App. 3d at 670, 672 N.E.2d at 1075 (noting that "neither physicians nor hospitals may shield themselves from criminal investigation by asserting the physician-patient privilege" and "courts have consistently rejected attempts by physicians and 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 (Ohio App. 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." *Fair*, 136 Ohio App. 3d at 527, 737 N.E.2d at 109. 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. 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.

C. The Court of Appeals Did Not Give Sufficient Consideration to the Necessity of the Patient Records to Medical Mutual's Investigation.

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 *Ohio 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 those 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 relative interests in favor of privacy and 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 at 825-26, 835 N.E.2d at 770. 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, 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.

D. <u>The Court Vastly Overstated the Privacy Interest at Stake in This Case.</u>

The Court of Appeals appeared to proceed from an 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* [CITE]. When the party requesting the information already has access to most of a patient's confidential information, however, as an insurer typically does, there is 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, therefore, 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 Were 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." Memorandum in Support of Jurisdiction of Appellant Medical Mutual of Ohio ("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* Affidavit of Amy C. Kelly [CITE], at 1 (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 would be entitled to examine before paying out an insurance claim. Nothing happened the information between when 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 requests—and is provided—Dr. Schlotterer's notes in support of a specific patient's diagnosis and treatment before Medical Mutual decides to pay the claim. If, a year later, in the course of a broader investigation into a pattern of fraudulent billing, 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 is appropriate even when it would result in the disclosure of otherwise confidential information 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 should automatically tip strongly in favor of disclosure and almost any public interest on the other side of the equation should 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. 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." *Medical Mutual of Ohio v. Schlotterer*, No. 89388, 2008 WL 94508 (Ohio App. 8 Dist., Jan. 10, 2008), at *5. The court's objections, however, 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. HIPAA 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* 45 C.F.R. § 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 already possesses. 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 legitimate 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 v. St. Elizabeth Medical Center*, 136 Ohio App. 3d 522, 737 N.E.2d 106 (Ohio App. 2000), the Court of Appeals balanced the public interest in disclosure of medical records with a patient's privacy interest by ordering the redaction of 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." *Fair*, 136 Ohio App. 3d at 527, 737 N.E.2d at 110; *see also Richards v. Kerlakian*, 162 Ohio App. 3d 823, 824, 835 N.E.2d 768, 769 (Ohio App. 2005) (approving the production of confidential medical records subject to a protective order "designed to protect the identities of the former patients"); *Ohio v. McGriff*, 109 Ohio App. 3d 668, 670, 672 N.E.2d 1074, 1075 (Ohio. App. 1996) ("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. State Medical Bd. of Ohio v. Miller*, 44 Ohio St. 3d 136, 138, 541 N.E.2d 602, 603 (Ohio 1989) ("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 . . .").

In *Cepeda v. Lutheran Hospital*, 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." *Cepeda*, [CITE], at *4. 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 *5. 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 in *Cepeda*, there is no reason why it could not be adequately protected 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: September [ ], 2008

ALLEN KUEHNLE STOVALL & NEWMAN LLP

____

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

Of counsel:

Kirk J. Nahra [(admitted *pro hac vice*)]
Howard Anglin [(admitted *pro hac vice*)]
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 Plans*