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IN THIS ISSUE

All Medicare fees are par, office, national unless otherwise noted.

PQRS

Check reporting preferences, provider mix before registering for GPRO by June 30

Check before the June 30 deadline to see whether your group practice is a good candidate to report Physician Quality Reporting System (PQRS) measures through the group practice reporting option (GPRO) — certain situations, including specialty mix and provider morale, may mean GPRO isn't for you.

CMS will accept for GPRO any group of two or more eligible professionals (EPs) who have reassigned their billing rights to a single Medicare-billing taxpayer identification

*(see **GPRO**, p. 4)*

HIPAA

New ONC HIPAA privacy, security guide offers real, if limited, help

A new edition of an ONC guide can help you with your basic electronic protected health information (ePHI) HIPAA work — particularly if you're new to or struggling with compliance.

The Office of the National Coordinator for Health Information Technology (ONC) issued its first update April 13 of its "Guide to Privacy and Security of Electronic Health Information" since 2011. A spokesman for ONC told *Part B News* that it would be appropriate, for example, for the manager of a

*(see **ONC**, p. 5)*

Practice management

Proposed EEOC rule explains how to run wellness program without violating ADA

Make sure your employee wellness program doesn't offer incentives exceeding 30% of the total cost of employee-only insurance coverage. Otherwise your practice could essentially be making it a requirement to participate and wind up facing a costly lawsuit.

The Equal Employment Opportunity Commission (EEOC) doesn't want business's wellness programs to lead to discrimination against employees, and it doesn't want employees to be forced to participate in the programs, attorneys say.

A proposed rule from the EEOC, posted April 20 in the Federal Register, was crafted to follow Affordable Care Act (ACA) provisions to promote wellness programs yet also reflect the goal of not violating the Americans with Disabilities Act (ADA) to limit employers' access to medical information.

To control health care costs and improve employees' health, many businesses — including medical groups — have turned to wellness programs in recent years. Wellness programs generally use incentives, such as discounts on the cost of health insurance, to encourage employees to participate.

Some wellness programs merely ask employees to complete health risk assessment questionnaires. Others offer rewards for things such as not smoking or participating in diabetes prevention.

Vanderbilt University Medical Center (VUMC) offers several wellness programs to its physicians and medical staff. Its diabetes prevention program has been one of the organization's success stories, says Dr. Mary Yarbrough, executive director of faculty and staff health and wellness, Vanderbilt University and Medical Center. For employees at an elevated risk — those with pre-diabetes or a history of high glucose, for example — VUMC offers "one-on-one" education and counseling while those at lower risk receive fewer direct interventions, says Yarbrough. "You really put your resources where your issues and problems are," she advises.

Many of VUMC's wellness offerings, which are tied to employees' health insurance, provide financial incentive for participating. "You can earn money that goes against your copays and deductibles," explains Yarbrough.

Providers affiliated with University of Washington Physicians, a group of more than 1,800 physicians and medical professionals in the Seattle area, have a number of "community building and wellness" programs at their disposal, says Kimberly Mishra, executive director of The Whole U wellness program at the University of Washington (UW).

The Whole U takes a "crowdsourcing" approach to wellness programs, using recommendations from employees to drive better health outcomes. Last year, UW physicians and other employees set a world record

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for the largest kettlebell workout when about 1,200 participants gathered for a group exercise. The success of the wellness program comes from its employee-directed spirit, says Mishra. "It doesn't feel prescriptive."

Prior guidance on wellness programs

The EEOC previously had no specific guidance on wellness programs beyond saying, in 2000, that plans could not require participation or penalize employees who did not participate, says attorney Frank Morris, head of Epstein Becker Green's Labor & Employment Practice Group in Washington, D.C.

However, HIPAA has had restrictions for many years, which have been modified and are now listed through the ACA.

The EEOC's proposed requirements — which list a maximum allowable incentive that businesses can offer employees to participate in a wellness program — are more restrictive than existing requirements under the ACA, Morris says.

The EEOC has worked to "meld together and reconcile" what the ADA and ACA stipulate, says John Gilliland, an Indianapolis attorney who specializes in labor issues affecting health care providers.

Ultimately practices and other businesses not in compliance with the EEOC requirement could be subject to a lawsuit by employees or the EEOC, Morris says.

Small employers could pay damages up to $50,000, while large employers could pay up to $300,000, Morris says. Companies with fewer than 15 employees aren't subject to the ADA.

Incentives can't exceed 30% of coverage

A major goal of the EEOC proposal is to limit incentives to participants. If the benefits of participating — or disincentives for not participating — are too large, it would be seen as though participating were not voluntary, Gilliland says.

In 2014, the EEOC filed several lawsuits against businesses it believed violated federal anti-discrimination law. In one case, an employee claimed that the consequence for not participating in a company wellness program was to have to pay 100% of health insurance, plus a $50 monthly surcharge, Morris says.

Under the EEOC proposal, the allowable incentive under all programs can't exceed 30% of the total cost of employee-only coverage. If, for example, the employer and employee contribution toward coverage is $5,000 combined, the most incentive an employer could offer an employee in connection to a wellness program is $1,500.

That's more restrictive than the ACA requirement, which says the incentive can't exceed 30% but takes into account covered dependents, Morris says.

And unlike the ACA requirement, the EEOC proposal maintains that limit for how much of an incentive businesses can provide to those in "participatory" wellness programs. Such programs include, for example, reimbursement for membership costs in a fitness center or rewarding employees simply for completing a health risk assessment, the Labor Department notes.

Also, under the EEOC proposal, the allowable incentive can increase to 50% of the cost of coverage if the program asks employees if they use tobacco but does not seek to verify the employee's response. Simply asking about tobacco use "is not an employee health program that includes disability-related inquiries or medical examinations," the proposal states.

Under the ACA requirement, businesses are able to offer a 50% incentive even if the plans test for tobacco use.

How to restructure wellness programs

Among the things practices should do, according to the proposed rule:

- **Design your program to promote health or prevent disease** among employees. A program that collects medical information on a questionnaire without offering follow-up information to employees — such as providing feedback about risk factors — would not promote health, the EEOC proposal states.
- **Explain clearly what health information will be sought.** If the wellness program is part of a group health plan, you must provide a notice employees can see — in understandable language — that will explain what medical information will be obtained and how the information will be used. The notice also should say who will receive the medical information and how it will be kept confidential.

Hand such information to employees and avoid medical or legal jargon in the explanation, Gilliland says.

- **Make sure data you get from the plan isn't identifiable for individual employees.** The goal should be to gather data "in aggregate terms that do not disclose, or are not reasonably likely to disclose,

the identity of specific individuals," the proposal states. *— Josh Poltilove (jpoltilove@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

Resources:

- View the EEOC's proposed rule at *http://1.usa.gov/1H7AMHt*. The public can comment until June 19.

GPRO

(continued from p. 1)

number (TIN). Note that practices with 100 or more EPs billing Medicare under the same TIN are required to use GPRO to report PQRS measures, says Jeanne J. Chamberlin, a practice consultant with MSOC Health in Chapel Hill, N.C.

The question is whether practices with two to 99 EPs should use GPRO.

"If you're not using a GPRO option, the practice will need to compile and submit data for each measure for each individual provider," says Chamberlin. "If there are two providers, it's not a big deal; if there are 99 providers reporting nine measures each, that's a lot of data to track."

GPRO has another major benefit: Even if some of your providers are PQRS slackers, your practice can still achieve GPRO targets and avoid a negative payment adjustment in 2017. If you do GPRO with the registry reporting method, for example, your practice has to submit nine PQRS measures for just 50% of your Part B patients — it doesn't matter how many providers submit them (*PBN 3/2/15*). But PQRS experts say some groups may prefer to have their providers report individually and offers these points to consider before you make that decision.

Weigh how GPRO affects provider morale

One factor in deciding whether to use GPRO that practices don't often consider is the way providers respond to it. It may not matter to management if the efforts of just a few hard-working providers meet your PQRS requirement under GPRO, but it may matter to those providers. "If providers are not equally invested, that can create conflicts — particularly when it comes to physician compensation," says Mark S. Bennehoff, health care consultant with SVA Healthcare Services in Madison, Wis. "If your compensation model is based on PQRS success and other quality measures and some providers are not fully invested, it may result in a loss of bonuses for the entire practice, which could cause friction."

On the other hand, for some clinical staff, anything that encourages group performance and group results, including a practice-wide PQRS push, may be welcome (*PBN 1/26/15*). "Commercial payers are increasingly using similar quality metrics to structure pay-for-performance programs to incentivize providers," notes Bennehoff.

"Groups may struggle with GPRO now, but they'll have it easier in the future," says Dr. David Nash, founding dean of the Jefferson School of Population Health in Philadelphia. "[HHS Secretary Sylvia] Burwell says in less than three years, 50 cents of the Medicare dollar will be connected to outcome measures. I would recommend that groups put in the work now, and it will pay dividends in the near future."

4 reasons not to go GPRO

1. Your group's specialty mix will make meeting measures difficult. While you can report GPRO successfully with some uninvolved providers, be careful that your provider mix does not make it difficult to meet the target. If the providers are all in one specialty, this shouldn't be a problem. But if you have a mix of orthopedic surgeons — for whom perioperative measures 21, 22 and 23 may be their best bets for reporting — and physical therapists, who can't report those measures, then GPRO might not work, says Leslie Witkin, CEO of Physicians First in Orlando, Fla. Because the group under the TIN has to report nine measures, you have to make sure the practice can report enough measures to meet the goal of reporting for 50% of your Part B patients.

2. You'll have fewer reporting methods. When you report as a group, you still have to pick a method of getting the data to CMS, and GPRO reporters can't use measure groups or qualified clinical data registries (QCDRs). If your practice is having trouble with its electronic health records (EHR), you may want to report measures groups because that method requires you to submit fewer records than other methods, says Lindsey Bates, market segment manager for PQRS at Wellcentive in Atlanta. If you use measures groups, you

can't do GPRO.

3. Your EHR may not let you. "Some EHRs limit electronic reporting for [meaningful use] and PQRS to individual providers only," says Chamberlin. Talk to your vendor and confirm its EHR's capability and experience with submitting under the GPRO program before committing to this approach.

4. Registration is soon. You'll have to hustle: To register for the GPRO by June 30, you're required to list the national provider identifiers (NPIs) in the group and select the reporting mechanism they will all use — and you can't change that information after the deadline, says Chamberlin.

If you do want to go for GPRO, make sure that you can get into the enterprise portal to do it. "I've had customers saying they want to self-nominate, then realizing that they don't know who has control of the IACS [Individuals Authorized Access to the CMS Computer Services] account," says Bates. "I encourage them to find out who's authorized to make the change. In some cases, their IACS administrator is no longer even there." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- GPRO registration page: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html*
- 2015 GRPO criteria: *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_GPRO_Criteria.pdf*
- 2015 PQRS GPRO Registration Guide: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-PQRD-GPRO-Registration-Guide.pdf*

ONC

(continued from p. 1)

small practice who is tasked with HIPAA compliance to use the guide to formulate questions for interviews with prospective HIPAA consultants. However, "a provider should not say, 'we followed the Guide and therefore we are HIPAA and MU [meaningful use] compliant,'" the spokesman said. "For specific questions, the provider should probably reach out to the Office for Civil Rights."

Beginners, small practices to benefit most

"It's a good, basic guide, especially for small practices," says Amy Fehn, health law attorney with Fehn, Robichaud & Colagiovanni, PLLC, Troy, Mich. She finds it particularly useful for beginners — the section "Low-Cost, Highly Effective Safeguards" (page 44), for example, shows "the bare minimum of what every practice should be doing. … Practices should start there and make sure they're doing the basics."

But the guide has shortfalls. For example, it lacks clarification on guidance about vendors who don't have formal access to protected health information (PHI) but do have "incidental" access, such as janitors (page 12). The vendors don't qualify as business associates under HIPAA, but to be HIPAA-compliant, "you have to show reasonable safeguards against access" with regard to janitors because generally "it is not possible to lock up every piece of PHI after hours," Fehn notes.

The section "Examples of Potential Information Security Risks with Different Types of EHR Hosts," including cloud-based services (page 43), offers "good language for risk assessment and a good format to consider how to talk about mitigation strategy," Fehn says.

"Sometimes when small practices try to do the risk assessment internally, they don't understand how to describe and document the risks and identify the mitigation strategies that they have taken," explains Fehn. "For example, the risk that a natural disaster could destroy a server is one of the risks listed for office-based EHRs, and an example they offer of a mitigation step is to store backups offsite. Most practices will have thought about this and will be taking this precaution already, but they need to know that this is the type of risk/mitigation that should be documented as part of their risk assessment document." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- ONC Guide to Privacy and Security of Electronic Health Information: *www.healthit.gov/sites/default/files/privacy-and-security-guide.pdf*
- ONC blog post: *www.healthit.gov/buzz-blog/privacy-and-security-of-ehrs/onc-guide-privacy-security/*
- ONC Security Risk Assessment Tool: *www.healthit.gov/providers-professionals/security-risk-assessment-tool*
- ONC's Questions for EHR Vendors: *www.healthit.gov/sites/default/files/privacy-security/Questions-for-EHR-Developers-2015-04.pdf*

Quality reporting

Include BMI in your reporting list for a PQRS measure that's one and done

Practices that are trying to make sure each provider reports the required number and type of quality measures should look to one of the easier measures to report: the body mass index (BMI) measure. But practices that have used this measure should review its guidelines for a few tweaks that could hinder this year's reporting effort.

The BMI screening and follow-up plan measure covers the cross-cutting measure requirement, hits one of the three quality domains and has a once-per-year reporting requirement for each eligible patient.

Providers should perform the measure on every patient age 18 or older on the date of the encounter. This is a slight change from 2014, when the denominator criteria indicated it should be performed for patients who were older than 18. It may be performed on patients during E/M visits **99201–99215**, in addition to such encounters as diabetes management training and counseling for obesity.

Timing is important because a provider can get credit for work that she did during an encounter that took place up to six months before the current encounter or for information collected by another provider.

The following three scenarios illustrate ways a provider could perform the measure:

- On Feb. 4, Dr. Orange sees Mr. Blue, a 67-year-old patient who has been referred to her by his primary care physician. The PCP sent a copy of Mr. Blue's medical record that includes his current BMI of 22, which is below the normal range for his age. On May 18, Mr. Blue returns to Dr. Orange's practice. During that visit, Dr. Orange gives him a follow-up plan.
- Same scenario as #1, except Dr. Orange gave Mr. Blue a follow-up plan on Feb. 4.
- Same scenario as #1, except Dr. Orange takes Mr. Blue's BMI on May 18 and finds it has gone up to 23, which is normal for his age. For this scenario, Dr. Orange would report a measure code that does not include a follow-up plan.

A provider may receive credit for this measure when he is not able to capture the patient's BMI and/or give the patient a follow-up plan for medical reasons or because the patient refuses. Use of codes to report non-performance of one or both parts of the measure when the provider does not give a reason should be rare.

Understand the 'normal' BMI ranges

Medicare wants providers to give follow-up plans for patients who are above or below the normal BMI, but what's normal varies by age. The normal BMI for a person aged 18 to 64 is between 18.5 and 25 kg/m^2. For patients aged 65 and older, it is between 23 and 30 kg/m^2.

You may use the National Institutes of Health's BMI calculator to get the patient's BMI in metric units if you don't have a calculator in your electronic health record system. The formula is Weight (kg)/Height (m) x Height (m) = BMI.

You or another provider must capture the patient's weight and height. Do not use information reported by the patient.

Issue a follow-up plan for abnormal BMI

To complete the measure when the patient is below or above the normal range, the provider must give the patient a follow-up plan, which CMS guidelines define as a "proposed outline of treatment to be conducted as a result of a BMI out of normal parameters." Examples of follow-up plans include nutrition counseling, advice to exercise or a referral to another provider, such as a registered dietitian or a surgeon. — *Julia Kyles, CPC-A (jkyles@decisionhealth.com)*

Editor's note: *Find a BMI screening and follow-up checklist at* Part B News *online.*

Practice management

Use recent HHS active shooter guidance to protect practice, patients

HHS' guidance on preparing your practice for an "active shooter" situation is worth following, for legal protection as well as your patients' and employees.

Issued in November 2014 in conjunction with the Federal Emergency Management Agency (FEMA), the FBI, the U.S. Department Homeland Security and the

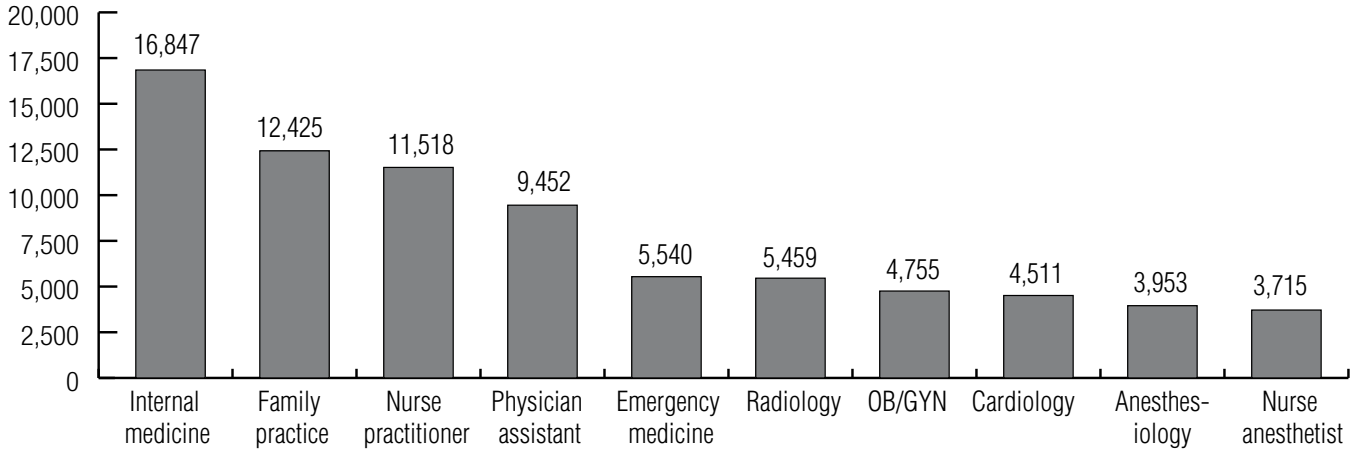
Benchmark of the week

GPRO growing as PQRS choice; primary care most likely to enroll

The group practice reporting option (GPRO) for the Physician Quality Reporting System (PQRS) isn't just for specialists: The eligible professionals (EPs) most likely to participate in GPRO reporting in 2013, the most recent year for which CMS has released reporting experience results, were primary care practitioners. The top four specialties were internal medicine, family practice, nurse practitioners and physician assistants.

All together, 677 practices representing 78,175 participating EPs reported GPRO in 2013, a great leap from 68 practices with 44,056 EPs in 2012, according to CMS' 2013 Reporting Experience Including Trends (2007-2014) for the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. GPROs performed well in terms of evading the 2015 negative payment adjustment to which EPs who don't meet 2013 PQRS requirements are subject — but not as well as those reporting as individuals. — *Roy Edroso (redroso@decisionhealth.com)*

Specialties with the largest number of eligible professionals participating in PQRS through the GPRO, 2013



Source: CMS' 2013 Reporting Experience Including Trends (2007-2014) for the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program (www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_eRx_Experience_Report_zip.zip)

U.S. Department of Justice, the document, "Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans," says it's "designed to encourage [health care] facilities to consider how to better prepare for an active shooter incident" — defined by Homeland Security as one in which a person is "actively engaged in killing or attempting to kill people in a confined and populated area."

The document offers several recommendations, including training for employees in the "run, hide, fight" model first devised by Homeland Security, says security trainer Robert Sollars, author of One is Too Many: Recognizing & Preventing Workplace Violence. It also recommends training staff in post-event care in the form of "psychological first aid."

"There's a big psych issue after the event happens," says John M. White, security expert and president of Protection Management LLC in Canton, Ohio. "Even if it's just a threat, afterward there's a fear factor, you know, 'I could have been killed.'"

This is a guidance document so it "does not create any requirements beyond those included in applicable laws and regulations." Armed invasion may be a sufficiently rare event that implementing a full-fledged plan may be excessive — but don't count on using that defense if you have an incident, get called to trial in a civil case and have to defend your preparations, says White.

"Speaking from the security expert witness side, I say [this document] will definitely come into play when there's litigation, when someone asks 'what could they have done?'" says White. The reason is its endorsement by HHS, a controlling authority for providers. "It's a good foundation on which to base protocol," he says. "During litigation cases, the defendant might say, 'we did the best we could,' and the attorney might ask, 'what was that?' — the idea being, since HHS released this, the providers should have known."

Conversely, White says, if a practice implements the guidance's suggestions to the best of their ability and records that action, they can use it to defend their protocols and their actions.

"In the event of an incident, there's always the threat of liability. Any shooting in a public area is going to result in a lawsuit sooner or later," agrees Ronald D. Heil, senior security advisor to Business Protection Specialists Inc. in Pittsburgh. "Having an active shooter plan and training for it at least takes lack of a plan off the table as a basis for a civil suit."

4 tips to protect your practice

Proper active-shooter planning is a big lift, says Paul Hughes, COO of security company Guardian 8 in Scottsdale, Ariz. Aim for the low-hanging fruit:

- **Train seriously.** Put your staff through the drills enough that the training "becomes muscle memory and reflex, like the way we teach people exactly what to do in the event of a fire, so when it happens, everyone acts in a predictable manner," says White. "If you waste a second over 'which exit am I supposed to use?' or 'am I supposed to call?' it could be fatal."
- **Identify key people to carry the most serious responsibilities.** "Most individuals involved in an active shooter incident likely will be non-active participants and/or bystanders," says Gary Buss, health care account manager at Tech Electronics in St. Louis. "Groups within a health care facility's staff should be identified to perform specific tasks in order to maximize overall response and provide guidance to others that are present in an active shooter environment."

Also explain to employees that in an active shooter situation, it's acceptable to take extreme measures, says White — "if there's no way to get out besides by breaking a window, let them break the window."

- **Change your office's layout.** "There may be a physical makeup of the facility that would not be helpful in an active shooter scenario," says Heil. "I told a hospital client: 'You have whole floors that are not patient areas; they're back-of-house. You could put up two new doors and suddenly the area is access-controlled and you've locked away a bunch of potential victims.'"
- **Use electronic security.** If your practice has access-controlled checkpoints of the badge-for-entry type so that only people who have to be in the area routinely have free access, "then people in department X can't get into department Y without permission," says Heil — and neither can a shooter. As a bonus, having these checkpoints "also lowers theft," he adds. — *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- Incorporating Active Shooter Incident Planning into Health care Facility Emergency Operations Plans: *www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf*

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