

January 2012

# BRACH EICHLER

# Health Law

# UPDATE



## FEDERAL UPDATE

### OIG OKs Proposed Coordination Referral Service for Health Professionals

On December 7, 2011, the Department of Health and Human Services Office of the Inspector General (OIG) issued a favorable Advisory Opinion, No. 11-18, concerning a proposed arrangement for a “coordination service” to be offered by a data management company that would facilitate the electronic exchange of information between health care practitioners, providers and suppliers (collectively, health professionals), and that would help them keep track of patients receiving services from other health professionals. The data management company currently offers multiple services to healthcare providers, including an “EHR service” that automates and manages medical record-related functions for physician practices. According to the data management company, offering the new coordination service in combination with the EHR service would assist health professionals who wish to make referrals in sending demographic, medical record, insurance and billing information, issuing appropriate referral reminders, tracking communications with other health professionals and exchanging information about orders, order results and health care recommendations.

Although the proposed arrangement potentially implicates the federal anti-kickback statute, and includes a per-click fee arrangement, the OIG concluded that it would not subject the data management company to administrative sanctions under the statute because the arrangement adequately reduced the risk that the remuneration provided under the arrangement could be an improper payment for referrals or for arranging for referrals of federal health care program business. The OIG based its conclusion on the fact that (1) the network would be comprehensive, allowing participation from all health professionals in the marketplace, and the data management company would not control or influence the decision as to which health professional a referral would be made; (2) the fees charged are reflective of fair market value; (3) although charges are on a per-click basis, the use of a transaction-based

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pricing model is reasonable under the proposed circumstances; (4) the fee structure arrangement would be unlikely to influence referral decisions in a material way and (5) the coordination service is intended to facilitate the exchange of information between health professionals, not limit the pool of professionals to which an ordering health professional may refer.

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### Consumers Share in Network Hospital Discount

The Department of Health and Human Services Office of the Inspector General (OIG) reviewed and approved a discount program that would allow network hospitals to waive Medicare in-patient deductibles of Medigap policyholders that would otherwise be covered by a Medigap policy. Part of the savings achieved by the Medigap insurer, for the insured’s use of a network hospital, would be passed to the policyholder in the form of a \$100 premium credit. The OIG analyzed the proposal under the federal anti-kickback statute, since prohibited remuneration under the statute may include waivers of Medicare cost-sharing amounts and the relief of financial obligations.

The OIG determined that the safe harbor for waivers of beneficiary coinsurance and deductible amounts or the safe harbor for premium reductions by health plans did not apply. Nonetheless, the OIG concluded that the discounts offered on in-patient deductibles by participating hospitals, coupled with the premium credits offered by the insurer to its policyholders, would present a low risk of fraud and abuse because (1) the arrangement would not increase or affect per-service Medicare payments; (2) the arrangement would not increase utilization, as the Medigap policy would have covered the insured’s deductible anyway; (3) any accredited hospital could participate, so competition among hospitals would not be affected and (4) medical judgment would not likely be affected. Finally, although the premium credit could be considered an inducement to Medicare beneficiaries, the

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OIG compared the arrangement to permissible differentials in coinsurance or deductibles that are part of a benefit plan design and found that it had the potential to lower Medigap costs for all policyholders.

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### **OIG Evaluation of Medicaid Managed Care Finds Fraud and Abuse Concerns**

The United States Department of Health & Human Services Office of Inspector General (OIG) recently issued a report of its investigation of Medicaid Managed Care. The OIG reviewed the files of the Centers for Medicare & Medicaid Services (CMS) Medicaid Integrity Group (MIG) from 13 states to review what steps the 46 Medicaid managed care entities (MCEs) in those states took to meet federal program integrity requirements, how the states oversee fraud and abuse safeguards and what major concerns MCEs and states have regarding Medicaid Managed Care.

The OIG determined that, although MCEs and states are taking steps to address fraud and abuse in managed care, concerns remain, including as related to services billed but not rendered, rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries.

In response to these findings, the OIG recommended that states implement one of several options, such as sending explanation of medical benefits to Medicaid beneficiaries, contacting them by telephone or mailing them questionnaires regarding the care they received. The OIG also recommended that CMS update and reissue the fraud and abuse guidance it published in 2000. CMS agreed with both recommendations, stating that it will advise states to work with their MCEs to determine and implement effective strategies for verifying that services billed by providers are received. CMS also stated that it will revise the 2000 guidelines once it finishes the development of a strategy to effectively address managed care program integrity.

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### **Hospital Did Not Commit Unfair Labor Practice by Implementing Flu Prevention Policy Requiring Face Masks or Medication**

On November 25, 2011, in Virginia Mason Hospital, Case 19-CA-30154, an Administrative Law Judge (ALJ) ruled that Virginia Mason Hospital did not commit an unfair labor practice when it implemented a flu prevention policy requiring non-immunized

nurses to wear facemasks or take antiviral medication. Prior to implementing the policy, the union successfully challenged a policy that would have required the entire workforce to be immunized against the flu. In response, the hospital implemented the flu prevention policy that was upheld by the ALJ, which was intended to protect patients, employees and visitors to the hospital from contracting influenza.

Unless and until the NLRB reviews the decision, it is not a binding decision for New Jersey hospitals and health care employers. But the decision does provide some guidance for hospitals and health care employers seeking to implement a flu prevention policy in the workplace. First, the ALJ rejected the hospital's arguments that it was required by state and federal regulations to require the facemasks. Second, the ALJ rejected the hospital's argument that the policy was a fundamental business decision that did not require bargaining. Instead, the ALJ found that the union had waived its right to negotiate over this issue based upon a management rights clause of the CBA. That clause recognized the hospital's right to operate and manage the workplace, including directing the nurses, determining the equipment to be used, and implementing improved operational methods and procedures. That clause, in conjunction with the hospital's infection control manual and undisputed evidence that the hospital never bargained with the union over any aspect of the infection control policy, was the basis for the finding in favor of the hospital. Therefore, hospital and health care employers should ensure a clearly worded management rights clause in any collective bargaining agreement to make sure they have the ability to implement appropriate flu prevention policy in the workplace without committing an unfair labor practice.

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## STATE UPDATE

### **New Jersey Bill Phases Out Tax on Cosmetic Medical Procedures: Awaiting Governor Action**

A bill recently passed by the New Jersey legislature would phase out New Jersey's cosmetic medical procedure gross receipts tax. The tax, initially passed in 2004, currently imposes a 6% gross receipts tax on the purchase of cosmetic medical procedures, defined as those procedures performed in order to improve an individual's appearance where such procedures do not significantly serve to prevent or treat illness or disease. This includes cosmetic surgery, hair transplants, chemical peels and cosmetic dentistry, as well as a host of other procedures. The tax is paid by the individual receiving the cosmetic procedure and collected by those billing for the procedure. The bill is meant to reduce the cost of such procedures as well as the administrative burden that the tax places on providers who are required to collect the revenue.

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The bill (A-3646/S-1988) would begin reducing the current 6% rate on such procedures to 4% starting on the first day of the calendar quarter after the bill is passed. The rate would then drop to 2% on or after July 1, 2012. The tax would subsequently be eliminated for procedures performed after July 1, 2013. During the final voting day of this legislative session on January 9, 2012, both the general assembly and the senate voted to approve the bill, and it has now been sent to Governor Christie for signature or veto.

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### Bill Requiring Surgical Practices to be Licensed by the NJDHSS as ACFs Passed Both Houses

We reported in a previous Health Law Update on S2780/A3909, which would require surgical practices to be licensed as ambulatory care facilities by the New Jersey Department of Health and Senior Services. In the last day of the legislative session, January 9, 2012, the bill was passed by both houses, and is now before Governor Christie for action.

If passed into law, all surgical practices in operation as of the effective date of the law will be required to become licensed within one year of the law's enactment. Surgical practices that are certified by the Centers for Medicare & Medicaid Services (CMS) or accredited by the American Association for Accreditation of Ambulatory Surgery Facilities or other accrediting body recognized by CMS, will not be required to meet the physical plant and functional requirements contained in New Jersey regulations. Further, surgical practices required to be licensed under the law will be exempt from the ambulatory care facility assessment, unless expanded to include additional rooms.

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### Proposed Legislation Providing Credit Against ACF Assessment For Value of Uncompensated Care Referred Out of Assembly Appropriations Committee

A bill which, if passed, would grant a tax credit against the ambulatory care facility (ACF) gross receipts assessment to the owners of ACFs for the value of the uncompensated care services provided by themselves and their physician employees at general hospitals to patients who qualify for charity care, was recently reported from the New Jersey State Assembly Appropriations Committee. The bill, A-3754, allows each ACF to take a credit against its gross receipts assessment liability equal to the Medicaid-priced amount of such health care services, so long as the physician

owner or physician employee has not received any direct or indirect compensation for such services from the hospital, patient or any third-party payor.

The bill further provides that the credit may not exceed the liability due for the ACF in any fiscal year, and any unused credit may not be applied in any other fiscal year in which a liability is due. The bill's counterpart in the Senate, S-2642, was introduced in the Senate in early 2011 and was referred to the Senate Health, Human Services and Senior Citizens Committee. During the final legislative session day on January 9, 2012, the bill was held and will need to be re-introduced in the next session. We will continue to monitor future developments.

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### New Jersey Bill Would Require Certain Advertising Disclosures

A bill originally introduced last June in the New Jersey Legislature, which requires certain health care professionals, working in an office, to disclose to patients their name, type of license and highest level of academic degree (A4185), was recently reported out of the Assembly Regulated Professions Committee. The bill requires that information must either be prominently displayed in the office of such a health care professional or in writing to a patient on the patient's first office visit.

The bill requires that:

- A person licensed to practice medicine or surgery by the State Board of Medical Examiners, who is also certified in a medical specialty, must disclose, while working in an office, the name of the certifying board or association
- Advertisements by a health care professional for health care services must include the professional's name, type of license and highest level of academic degree
- Certain health care professionals who provide information regarding health care services on an internet website that is directly controlled or administered by that professional or that professional's office personnel, must prominently display on that internet website their name, type of license and highest level of academic degree

The bill was not addressed in the last day of the legislative session held on January 9, 2012.

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### Medicinal Marijuana Program Rules Take Effect; BME Clarifies Position on Prescribing Marijuana

On December 19, 2011, the rules governing New Jersey's Compassionate Use Medical Marijuana Act went into effect. The adopted rules – originally proposed by New Jersey's Department of Health and Senior Services (DHSS) – are identical to those proposed by DHSS in February of 2011.

The New Jersey State Board of Medical Examiners (BME) adopted its own rules, which were revised from the BME's originally proposed rules. The revisions came in response to controversy surrounding the Legislature's interpretation of the BME's rule as requiring physicians to periodically attempt to wean patients off of their medicinal marijuana. The revised rules retain a provision requiring physician reassessment of the patient's medicinal marijuana use every three months. However, the new rule makes clear that physicians can continue to prescribe medicinal marijuana if it is helping the patient reach his or her treatment objectives with no untoward side effects, physical problems or psychological problems. Notwithstanding this clarification, if such problems do arise, then the prescribing physician is required to either (1) modify the dose of marijuana, (2) undertake a trial of other drugs or treatment modalities or (3) discontinue the use of marijuana. Additionally, physicians required to take action must also consider referring the patient for independent evaluation or treatment.

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## HIPAA CORNER

Our December, 2011 HIPAA Corner reported on the recent notice from the Office for Civil Rights (OCR) regarding its pilot program to perform 150 privacy and security audits of covered entities. Since such announcement, OCR posted a sample letter that it intends to use as a template for the letters issued to those covered entities chosen for audit. According to the letter, the audit process will begin within 30 to 90 calendar days from the date of the letter.

In the letter, OCR informs recipients that it has hired KPMG LLP to perform the audits in accordance with OCR and general government auditing standards. The letter states that KPMG "is requesting and reviewing . . . documents solely as a contractor to OCR and on its behalf and pursuant to its audit authority." Thus, covered entities that receive this letter should cooperate with KPMG's request for information and documentation.

More information regarding the OCR's audit process can be found at: <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/index.html>.

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