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Health Law Check Up

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SURPRISE!!! THE NJ OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT, AND ACCOUNTABILITY ACT GOES FORWARD AND STALLS

On November 17, 2015, New Jersey lawmakers forged ahead with the controversial legislation that addresses, among other things, "surprise" medical bills from out of network providers. According to its sponsors, the purpose of the Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act (A-4444/S-20) is to ensure that patients are informed about out-of-pocket costs before they schedule a service. The latest version of the bill removed a major provision that would have included use of the Healthcare Price Index (HPI), which would have allowed consumers and researchers access to average prices for healthcare services delivered inside patients' insurance networks. Along with removing the HPI (now contained in a separate bill), legislators made several other significant changes to the bill.

First, self-funded health plans would have the option to participate in the new system set up by the bill. Second, the Act provides for binding arbitration to resolve disputes between doctors and hospitals and insurers and patients. However, billing disputes could receive a peer review by independent medical experts before going to arbitration and the process would now be limited to reimbursements of at least $1,000. Third, patients will not be required to pay more for emergency services than the least-expensive service in their insurance network. Although notice would still have to be given before ***scheduling*** an out of network service, the bill dropped the requirement that providers inform patients of potential out-of-pocket costs 30 days before ***delivering*** a service.

The bill also provides that it is a violation for an out of network health care provider to waive all or part of a patient's deductible, copayment or coinsurance as an inducement to seek covered services from the provider.

The Medical Society of New Jersey continued its criticism of the bill fearing the concentrated power of insurers will leave physicians with less power to negotiate fair rates.

More recently, however, on December 11, 2015, the Legislation stalled when the sponsor pulled it from a committee agenda after learning it did not have enough votes to pass. The bill's sponsor, Sen. Joseph Vitale asked the Senate Commerce Committee to pull the bill from consideration because of "additional questions by members, and the gross misrepresentation of the facts by greed-driven special interests."

We will continue to monitor the status of the "surprise bill" legislation.

INTRODUCING STARK PHASE V

On November 16, 2015, the Centers for Medicare and Medicaid Services ("CMS") published the most significant changes to the physician self-referral law ("Stark Law") regulations since 2008. Currently being referred to as "Stark Phase V," these changes constitute the fifth substantive rulemaking under the Stark Law. This rulemaking, which was part of the Medicare Physician Fee Schedule, contains a number of important changes. Several amendments are aimed at easing the burden of existing compensation exceptions related to the signature and writing requirements; the length of term requirement; holdover arrangements, and the definitions of the terms remuneration, stand-in-the-shoes and locum tenens.

However, the timeshare exception applies only to limited arrangements predominantly for the provision of E&M services.

Phase V clarifies a number of issues that routinely arise within the context of documenting compliance with the Stark Law, including:

- allowing an arrangement that qualifies for a Stark Law exception to continue indefinitely after the arrangement's expiration date;
- granting all parties involved 90 days to seek a Stark Law exemption to obtain missing signatures on an agreement;
- clarifying that leasing arrangements involving office space, equipment and/or personal services must last at least one year to qualify for a Stark Law exception;
- clarifying that parties to an arrangement seeking a Stark Law exception do not need to have a formal written contract;
- allowing for the sharing of office space, assuming: the arrangement is in writing and is between a hospital and a physician; and
- clarifying the policy that "incident to" Medicare Part B, services must be billed by the supervising physician or practitioner.

In addition, CMS introduced two new Stark Law exceptions: (1) for timeshare arrangements for the use of office space, equipment, personnel, items, supplies and other services, and (2) for assistance to compensate non-physician practitioners under certain circumstances. The timeshare exception indicates a departure from CMS' historical reluctance to address the sharing of space. However, the timeshare exception applies only to limited arrangements predominantly for the provision of E&M services.

OIG ISSUES ALERT ON PHYSICIAN COMPENSATION AND MEDICAL DIRECTOR ARRANGEMENTS

On June 9, 2015, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a Fraud Alert entitled "Physician Compensation Arrangements May Result in Significant Liability" (OIG Alert). The OIG Alert reinforces the OIG's continued focus on suspect physician compensation

arrangements. The OIG Alert provides examples of 12 recent settlements between the OIG and physicians involving medical directorships and other compensation arrangements being questioned by the OIG. The key issue raised by the OIG in many of the questionable arrangements, including those involving medical directorships, is that compensation did not reflect the fair market value of the services being performed. The OIG reiterated that if even one of the purposes of an arrangement is to pay for federal health care program referrals, then the Anti-Kickback Statute may be violated. The OIG Alert emphasizes the importance of confirming that medical director payments and other physician compensation arrangements are structured in a manner that is consistent with the fair market value of the services actually being rendered.

The OIG Alert warns that, in addition to liability for the hospital or facility, physicians could be held liable for entering into questionable arrangements. The OIG found that "the physicians were an integral part of the scheme and subject to liability under the Civil Monetary Penalties Law." In the OIG Alert, the OIG "encourages physicians to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them."

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CHECK--AND DOUBLE CHECK--TO AVOID PROFESSIONAL LIABILITY IN NEW JERSEY

A recent New Jersey Supreme Court decision warns that health-care facilities that fail to do appropriate due diligence before granting privileges to physicians could face potential liability for that failure. In *Jarrell v. Kaul*, (2015 BL 315262, N.J., No. A-42-13, 9/29/15), the Supreme Court decided three issues: (1) whether patient Jarrell had a direct claim against Dr. Kaul for his failure to maintain malpractice insurance covering the procedure, (2) whether Jarrell had a cause of action against Dr. Kaul for lack of informed consent based on Kaul's failure to tell him he lacked the insurance and (3) whether the trial court properly granted summary judgment for the surgery center based on its credentialing of a physician who lacked the required insurance.

Plaintiff James Jarrell sought treatment from Dr. Richard Kaul for back pain. The doctor performed a spinal fusion procedure at Market Street Surgical Center (MSSC). At the time of the surgery, Dr. Kaul was required by New Jersey law (NJSA 45:9-19.17) to have medical malpractice liability insurance or to have a posted letter of credit demonstrating financial responsibility. Although Dr. Kaul had malpractice insurance, his policy expressly excluded spinal surgery procedures. Jarrell brought suit alleging that the physician negligently performed his surgery, leading to greater pain and a revision surgery.

The Supreme Court held that neither the statute, nor the implementing regulations expressly provide that an injured patient has a direct cause of action against a treating physician who does not comply with the statutory financial responsibility provisions. On the contrary, the court explained that the Legislature specifically provided that an action by the BME would be the most likely vehicle to ensure compliance with the law. A majority of the court also said a physician's failure to tell his patient that his malpractice insurance wouldn't cover him for the procedure in question did not give rise to a lack of informed consent claim.

Significantly, the Court held that an ambulatory surgical facility may be liable to a patient for injuries caused by a physician who had only limited medical malpractice liability coverage. The Court characterized Jarrell's claim against MSSC as an action based on negligent hiring. In granting privileges to a physician who doesn't have the appropriate credentials, a facility may be exposed to liability for hiring an incompetent contractor. The court remanded the case to the trial court for further proceedings.

Tip: To avoid potential liability, health-care facilities should determine for themselves whether a physician seeking privileges has the requisite insurance. Privilege applications should, for example, ask the physician for the name of his or her insurance provider, the policy number and a copy of the certificate of coverage, including a requirement that the physician inform it of any changes in the insurance coverage and/or update the information on a yearly basis.

SPOTLIGHT ON TELEMEDICINE

Telemedicine is here to stay in 2016 and continues to be a rapidly evolving area of health law. Specifically, as of December, 2015:

- 48 states have adopted formal state definitions of telemedicine services;
- 29 states have enacted laws requiring insurers to pay for telemedicine;
- 11 states enacted legislation adopting the Federation of State Medical Boards' (FSMB) Interstate Medical Licensure Compact; and
- 9 additional states have introduced legislation seeking enactment of the FSMB Compact.

The FSMB Compact provides for an expedited licensure process for eligible physicians and is meant to improve license portability and increase patient access to care. Many states have also adopted a national model policy that allows patients to establish relationships with a healthcare provider through a videoconference rather than an in-person meeting.

New York Embraces Telemedicine

Early in 2015, Governor Cuomo signed into law legislation allowing certain licensed health providers in New York to be reimbursed for live video/audio, store-and-forward, and remote patient monitoring from private insurers. Under the new law, private insurers are required to cover services via telemedicine if provided by hospitals, home care and hospice agencies, licensed physicians, PAs, dentists, nursing, midwives, podiatrists, optometrists, ophthalmic dispensers, psychologists, social workers, or speech language pathology and audiologists. Budget withstanding, the law also authorizes the Medicaid agency to expand coverage and reimbursement of telemedicine.

Governor Cuomo also signed a law last month that adds licensed physical and occupational therapists to the list of telehealth providers eligible for reimbursement under the state's parity law. The latest changes are timely as the new law goes into effect January 1, 2016.

New Jersey Trails Behind In Addressing Telemedicine.

Although several bills have been proposed, New Jersey is one of only two states in the nation that has yet to address the definition of telemedicine services. Senator Joseph F. Vitale, who recently convened a Senate Health committee hearing on telemedicine last week, indicated there is broad agreement that there needs to be "an organized process" for regulating telemedicine in the state. That process includes defining what services telemedicine covers and how payment should be made for telemedicine services. Vitale said he would like to have bills addressing telemedicine early in the legislative session that starts in January 2016.

Please check back in 2016 for updates and new advancements in this burgeoning area of the law in New Jersey and elsewhere.

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