WILENTZ
—ATTORNEYS AT LAW—

Health Law Check Up

MAY 2017

In this issue:

Useful legal links:

OIG Enforcement Cases: http://bit.ly/2qRIItU

Fair Health Consumer Cost Look Up: http://bit.ly/2reb2aS

New Jersey Doctor Profiles: http://bit.ly/2qLNs40

WARNING: NEW YORK PERCENTAGE BILLING ARRANGEMENTS UNDER ATTACK. MEDICAID FRAUD UNIT IS SEEKING RECOUPMENT FROM PROVIDERS USING PERCENTAGE BILLING ARRANGEMENTS

By: Grace D. Mack, Esq.

New York's Medicaid Fraud Control Unit ("MFCU") is seeking recoupment from various healthcare providers in New York State who have percentage of collection arrangements with their outside billing companies based on MFCU's determination that such billing arrangements are illegal under the Medicaid law and may also constitute unprofessional conduct under New York's Education Law.

It is MFCU's position that "Billing agents are prohibited from charging Medicaid providers a percentage of the amount claimed or collected. In addition, such payments arrangements, when entered into by a physician, may violate the Education Law and State Education Department's regulations on unlawful fee-splitting."

MFCU states "Although we understand that these practices are very common when it comes to billing other third party health insurance programs, including the Medicare program, it is not an acceptable arrangement under the Medicaid program."

MFCU warns that the provider may be required to refund the resulting Medicaid payments. MFCU also cautions healthcare providers that they should only contract with billing agents who are enrolled in the Medicaid program.

Based on the MFCU position, the Medical Society of the State of New York (MSSNY) is urging its members to amend the fees they pay to their billing companies for Medicaid claim submissions so that they reflect either: (1) payments based on time; or (2) a flat fee for claims submitted.

New York Providers, especially those who accept Medicaid, should immediately review their billing contracts to ensure that they do not provide compensation to the billing company based on a percentage of collections.

13 STEPS FOR CLOSING A NEW JERSEY MEDICAL PRACTICE

By: Lisa Gora, Esq.

Thinking of closing your medical practice? Whether this decision stems from wanting to retire or to seek new employment, as the owner of a medical practice in New Jersey, you must take certain steps prior to closing your medical practice, including but not limited to the following list below.

1. **Notify Patients about the Anticipated Closing of Practice.** New Jersey Board of Medical Examiners' (the "Board") Regulations (NJAC 13:35-6.22) provide that a physician must notify his or her patients, in writing, that physician shall no longer provide care to the patient as of a certain date. The notification shall be sent out to patients no less than 30 days prior to the date on which care is to be terminated and to patients treated within the six months prior to the date the practice shall close (as described further in #2(B) below), and shall be made by certified mail, return receipt requested, or other proof of delivery, sent to the patient's last known address. Additionally, the physician shall provide patient all necessary emergency care or services, including providing the patient with all necessary prescriptions until the date on which services are terminated. The provision of any such emergency care or services shall not be deemed to manifest any intention to reestablish a physician-patient relationship.

2. **Establish a procedure for patients to obtain copies of their records and notify the Board.** N.J.A.C. 13:35-6.5 provides that a physician must:

A. establish a procedure by which patients can obtain a copy of their records or have their records transferred to another practitioner.

B. make reasonable efforts to directly notify patients treated within the six months prior to the practice closing date that you are closing your practice, and inform them of the manner in which they may obtain copies of their records.

C. publish a notice of the closing of your practice and the established procedure for the retrieval of patient records, and the location at which the records will be permanently maintained, in a newspaper of general circulation in the geographic location of your practice, at least once each month for the first three months after the closing of your practice. Such notice shall be submitted to the Board after the first publication.

An additional consideration regarding patient notice: Please note that you should also review your contracts with your insurance payors to determine if such contracts require notices to be sent to ALL members of the specific plan treated by the practice regardless as to when services were last provided. Such a requirement may cause you to modify your notice to patients according to specific requirements set forth by the payor.

3. **Properly dispose of controlled substances.** If your office has an inventory of drugs, those must be disposed of in accordance with federal and state requirements. Please contact the Special Agent in charge at the local DEA field office, identified below, for authority and instructions to dispose of such substance. You may also contact the Drug Control unit for such authority and instruction:

Drug Enforcement Administration
80 Mulberry Street, 2nd Floor
Newark, NJ 07102
t: 973-776-1100 | f: 973-776-1166

4. **Termination or Transfer of Licenses, Registrations, Certifications or Permits.** All federal, state or local permits, certifications or registrations ("Licenses") held in the name of the practice (and/or physicians) will need to be reviewed to determine the specific requirements to address such Licenses upon the practice's closure. By way of example, without limitation, such Licenses may include:

A. Drug Enforcement Agent ("DEA") Numbers. A physician who holds a DEA number should notify the DEA in writing and enclose physician's DEA Controlled Substance Certificate and any unused Official Order Forms (DEA Form-222). Prior to forwarding the forms, please cross out and write "void" on all controlled substance order forms. Please send notice via certified mail with return receipt.

B. National Provider Identifier ("NPI"). Any physician with an NPI must notify the National Plan and Provider Enumeration System ("NPPES") when the physician plans to close his/her practice or change the address of the medical practice. NPPES can be contacted by calling 1-800-465-3203.

C. Other registrations or permits as applicable should be reviewed. Such licenses, registrations and permits may involve jurisdictions other than New Jersey.

5. **Notify Medicare, if applicable.** If you are closing your medical practice and taking employment with another provider, you, or your new employer, may have to notify Medicare of the change in your address (and billing information) and the re-assignment of your benefits to your new employer. You, or your new employer, should complete either, the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or the paper enrollment application form, CMS-855I and CMS-855R. Notice via certified mail, return receipt requested is recommended. You may also have to terminate the Practice's Medical Part B billing number by voluntarily terminating the Practice's enrollment and completing certain sections of form CMS-855B.

6. **Notify Medicaid, if applicable.** If you are closing your medical practice and/or taking employment with another provider, you, or your new employer, may have to notify Medicaid, if applicable, of your change in your address (and billing information), please contact Molina Medicaid Solutions Provider Enrollment Unit at 609-584-1192. You may also have to terminate the Practice's participation with New Jersey Medicaid, if appropriate.

7. **Review Third-Party Payor Contracts.** Please review the contracts of the third party payors which you participate in to determine if the contract needs to be terminated. Such contracts have specific advance notice requirements and must be carefully reviewed. Send written notification of such termination to the payor in accordance with the contract's requirements. You should review your participation agreement to make sure you don't have a continuation of care obligation. Please send notice via certified mail with return receipt.

8. **Terminate any Staff Privileges where appropriate.**

9. **Professional Liability and Other Insurance Coverage.** Your professional liability coverage carrier must be contacted to determine what needs to be done regarding closure of the practice and to ensure tail coverage is in place if necessary. In addition, the Practice must also determine whether any other insurance coverage must remain in place following the closure of the Practice.

10. **Billing and Collection.** Arrangements will need to be made for billing and collection services to continue after the practice closure for an appropriate period of time.

11. **Pay Creditors; Dissolve Practice.** The Practice must take appropriate company action and file documents with the State of New Jersey and other governmental agencies providing notice of its dissolution. This action can only be taken after the Practice consults with its legal and tax advisors. Confirm that your accountant has filed all annual reports on behalf of the company and paid all applicable taxes and fees. All assets not otherwise transferred will be to be sold or otherwise disposed of.

12. **Evaluate the terms of the lease and give appropriate notice to landlord. Evaluate the terms of all other contracts with vendors, suppliers, cleaning services.** Review the lease and all other applicable contractual arrangements and/or seek advice from an attorney with regards to the review of the lease and/or other contracts in place with the practice.

13. **Personnel.** The Practice must determine if any employees or independent contractors have a written contract with the Practice. If so, such contracts must be reviewed to determine the Practice's right to terminate the contract. Arrangements must also be made to terminate the employment of the Practice's "at-will" employees. Benefits due any such employees at termination of employment should be timely paid. The Practice should

consider whether severance packages should be offered and whether to seek releases from any of its employees. Please consult an attorney in this regard.

This a general list of certain steps to be taken when closing a medical practice and does not apply to all situations. You still need to seek the advice of an attorney so that the specific circumstances of your situation can be taken into consideration and evaluated in light of current applicable legal and contractual requirements.

NEW JERSEY OUT-OF-NETWORK UPDATE

By: Grace D. Mack, Esq.

Increased Focus on the NJ Surprise Bills Legislation

As you know, New Jersey legislators have been considering laws regulating surprise bills by out of network providers for over 8 years. Recently, activity has intensified.

Senator Vitale Weighs In

The latest proposed law (S-1285 http://www.njleg.state.nj.us/2016/Bills/S1500/1285_I1.HTM) was scheduled for a hearing in December, but was pulled from the agenda due to concerns from various stakeholders. Recently, Sen. Joseph Vitale, a sponsor of the proposed law, stated: “I’m hopeful that shortly we will have reached consensus with most of the stakeholders,” and suggested that the bill could see legislative action soon.”

The most controversial issue with the bill involves the process by which healthcare providers would resolve disputes with insurance companies. In the current version, the bill would set a range of 90 percent to 250 percent of the Medicare rates as parameters on these decisions.

Governor Christie Weighs In

During Gov. Christie’s annual budget speech on March 7th, he voiced his concern with “surprise bills” and the cost of medical procedures performed at healthcare facilities that are not part of patients’ insurance networks.

Gov. Christie focused on the need for out-of-network billing reform and called on the state Legislature to take action soon to address the problem.

Horizon Weighs in

Christie called on Horizon in his speech to voluntarily establish an annual fund to help cover the cost of addiction treatment and other healthcare expenses for poor patients who lack insurance.

Horizon leaders shifted the focus to urge state officials to make the out of network debate a priority. Horizon spokesman Kevin McArdle responded by stating “Instead of taking our members’ reserves, we should partner to create a permanent and stable source of revenue to help New Jersey’s less fortunate by tackling, once and for all, the $1 billion dollar out-of-network billing abuse and surprise medical billing problem”.

The Wilentz Health Law Team will continue to monitor the status of the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act.

Out-of-Network Reimbursement Upheld by the NJ Appellate Division

On June 29, 2016, the New Jersey Appellate Division in *Aetna Health, Inc. v. Srinivasan*, affirmed a trial court's order and final judgment dismissing Aetna's claims against an out-of-network cardiologist alleging excessive billing and insurance fraud, and awarding nearly $2,000,000 to the doctor for unpaid claims. The Appellate Division recognized that the physicians, in that case, were allowed to establish their own fee schedule, and declined to impose a fair market value standard noting that the fees charged by physicians were subject to the oversight of the New Jersey State Board of Medical Examiners.

IT'S A TOUGH CHOICE: The decision to be out-of-network is not an easy choice. Opposition from the insurance industry and the current backlash from surprise bills create significant obstacles. On the other hand, in the Srinivasan case, in the end, the provider was able to succeed against Aetna and obtain reimbursement for out-of-network services.

FREE OR DISCOUNTED LOCAL TRANSPORTATION: TO OFFER IT OR NOT?

By: Lisa Gora, Esq.

On December 7, 2016, the Department of Health and Human Services, Office of the Inspector General (the "OIG") published a final rule [1] (the "Final Rule") (that took effect January 6, 2017) that, among other things, added a new safe harbor to the Federal Anti-kickback Statute (the "Federal AKS") [2] in connection with free local transportation arrangements (the "Local Free Transportation Safe Harbor"). If all of the requirements of the Local Free Transportation Safe Harbor are met, the free local transportation business arrangement would be protected from liability and the entity offering the free transportation would not be subject to sanctions under the Federal AKS or civil monetary penalties under the Federal Civil Monetary Penalty Law [3].

The Local Free Transportation Safe Harbor provides that local transportation offered to federal health program beneficiaries by an "eligible entity" will not be deemed "remuneration" under the Federal AKS (and the entity not subject to penalties and sanctions under the Federal AKS) if the service being offered by the Provider meets all of the following conditions:

A. **"Eligible Entity" allowed to provide free or discounted local transportation:**

- "Eligible Entity" includes any individual provider or entity that provides services, except individuals or entities that primarily supply healthcare items, including but not limited to, durable medical equipment supplies or pharmaceutical companies.

B. **Facility to Set a Policy Regarding Free Transportation:**

- Entities must have a set policy regarding the availability of transportation assistance, and the policy must be applied uniformly and consistently to all patients.
- The OIG does not require each entity to maintain individualized documentation for each patient to whom transportation is provided, but the OIG recommends maintaining documentation for each patient to whom transportation is provided as a best practice to demonstrate compliance with the requirements of the policy and the consistent and uniform application.
- The policy must not be related to the past or anticipated volume or value of federal health care program business: For example, transportation services cannot be offered only to individuals on Medicaid or Medicare. Instead, a health center may take into account an individual patient's need for transportation.

C. **Limited Modes of Transportation:**

- The modes of permissible transportation are limited and exclude air, luxury and ambulance-level transportation.

D. **Prohibition on Marketing:**

- Transportation assistance may not be publicly advertised or marketed to patients or others who are potential referral sources.
- This prohibition includes marketing on websites, in printed materials or during transportation.
- Providers may inform patients that transportation is available if it is done in a targeted manner. For example, if a patient learns that he or she needs to come to a follow-up appointment, or is scheduling a procedure that might require a safe ride home, it would be permissible to ask if the patient has a reliable mode of transportation and then discuss the free transportation provided by the ASC.
- Signage designating the source of the transportation on vehicles used to transport patients would not be "marketing."

E. **Free Transportation is Available Only to "Established Patients" within the Local Area:**

- "Established Patient": Under the definition in the Final Rule, a patient is "established" when such person has selected and initiated contact to schedule an appointment with a provider or supplier, or who previously has attended an appointment with the provider or supplier, or who has already received a service from the provider. However, it is not necessary that the patient previously received care from the provider to be considered "established." For example, upon a person making an initial appointment with the provider, the provider may offer transportation regardless of whether the patient has received services from that provider in the past. A provider cannot reach out to a new patient to schedule an appointment with the provider and couple such solicitation with an offer of transportation.
- "Within the local area": The safe harbor protects local transportation which is defined as up to 25 miles as the crow flies (not driven) in urban settings from provider's location and up to 50 miles in rural areas from provider's location. The distance is measured directly and includes any route within that radius (even if such route is more than 25 or 50 miles when driven).

F. **Transportation must be for purposes of obtaining medically necessary items and services:**

- The safe harbor does not protect free or discounted local transportation for other purposes (such as applying for government benefits, obtaining social services, or visiting food banks or food stores).

G. **Payment to the Drivers of such Free Transportation:**

- Driver or Private Company hired by the ASC: The entity cannot pay the driver or person/entity involved in arranging for the transportation on a per-patient-transported basis. It could pay on the basis of total distance traveled by a vehicle.
- Non-Private Transportation (such as a taxi or bus): The transportation could be paid for, or reimbursed to individual patients through, for example, taxi vouchers or bus fare, or cash reimbursement if the patient has a receipt to show that he or she incurred the cost of the transportation.

The Local Free Transportation Safe Harbor also protects the offering of a shuttle service to federal health program beneficiaries by eligible entities subject to certain additional restrictions. The term "shuttle" refers to a vehicle (except for air, luxury or ambulance) that runs on a set route and on a set schedule.

Please also note that free transportation services may also implicate other laws, including the New Jersey Anti-kickback statute [4] for practices in New Jersey.

If you plan on offering free local transportation to your patients, please seek legal guidance to review the Local Free Transportation Safe Harbor and other applicable laws.

_____
[1] 81 F.R. 88368
[2] 42 U.S.C. 1320-7b(b)
[3] 42 U.S.C. 1320-7a(a)(5)
[4] N.J.A.C. 13:35-6.7(c)(1)

SPOTLIGHT ON NEW JERSEY TELEMEDICINE LAW UPDATE

By: Grace D. Mack, Esq.

The majority of states have already enacted legislation governing telemedicine. New Jersey lawmakers are considering a bipartisan Bill (S291) which would address the growth of telemedicine in New Jersey. On November 3, 2016, the NJ Senate Budget and Appropriations Committee reported favorably on the bill. S291 is moving forward for further consideration by NJ legislators. It is most likely that the bill will chance significantly before enacted.

The proposed NJ legislation addresses the use of telemedicine, including how it must be practiced and how providers will be compensated as follows:

- The Bill would allow patients to establish relationships with doctors remotely thereby eliminating the need for an in-person examination under most circumstances.
- There is an exception for the prescription of “controlled dangerous substances” which requires an initial in-person examination and a subsequent in-person visit with the patient at least once every three months (other than when a board certified psychiatrist or psychiatric nurse practitioner is prescribing a stimulant for use by a minor patient with written consent for the waiver of these in-person examination requirements from the minor child’s parent).
- Unlike some other states, the Bill defines the originating site broadly to include the use of telemedicine in home settings. This creates an option for patients who have limited access to transportation or who need immediate advice but not necessarily an emergency room visit.
- The Bill would also require insurance companies to compensate providers at the same rate whether an appointment is conducted remotely or face-to-face. **As you may expect, this provision is being opposed by commercial payors.**
- “Telemedicine” does not include the use of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.
- Any health care provider who engages in telemedicine would be required to ensure that a proper provider-patient relationship is established, including: (1) properly identifying the patient; (2) disclosing and validating the provider’s identity and credentials; (3) obtaining suitable patient consents, which may be oral, written, or digital in nature, so long as the chosen method of consent is deemed appropriate under the standard of care; (4) establishing a patient history, and a diagnosis and treatment plan, either through the in-person examination of the patient, or through telemedicine; (5) discussing with the patient, the diagnosis and evidence therefor, as well as the risks and benefits of various treatment options; (6) ensuring the availability of coverage for appropriate follow-up care; and (7) providing the patient with access to a summary of the encounter or the patient’s medical record, and, upon the patient’s request and consent, timely sharing the summary of the encounter with the patient’s primary health care provider or other health care provider of record.

- Any health care provider engaging in telemedicine or telehealth in NJ would need to: (1) be licensed, certified, or registered to provide services to patients in New Jersey, in accordance with applicable State law; (2) comply with regulations adopted by the appropriate State licensing board or other professional regulatory entity; and (3) act in compliance with existing requirements regarding the maintenance of liability insurance.
- The Bill applies to licensed physicians, practical nurses, registered professional nurses, advanced practice nurses, psychologists, psychiatrists, psychoanalysts, clinical social workers, physician assistants, professional counselors, respiratory therapists, speech pathologists, audiologists, optometrists, pharmacists, and any other health care professional to engage in telehealth and telemedicine. This authorization would extend to mental health screeners.

We expect to see activity on this bill in the coming months. We will continue to monitor S 291 and other telemedicine and telehealth developments in New Jersey.

EDITOR

Grace D. Mack | Shareholder
Business and Healthcare Law Teams
732.855.6025
gmack@wilentz.com

HEALTHCARE TEAM MEMBERS

Michael F. Schaff | Shareholder
732.855.6047
mschaff@wilentz.com

Brett R. Harris | Shareholder
732.855.6122
bharris@wilentz.com

Peter A. Greenbaum | Shareholder
732.855.6426
pgreenbaum@wilentz.com

Alyson M. Leone | Shareholder
732.726.7474
aleone@wilentz.com

Jason J. Krisza | Associate
732.855.6452
jkrisza@wilentz.com

Lisa Gora | Associate
732.855.6124
lisagora@wilentz.com