



KSDB Health Law INSIGHTS

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Stark update and anti-markup rules – where do we stand now?

By Michael R. Burke, Esquire

The Centers for Medicare and Medicaid Services (“CMS”) published Phase III of the final regulations under the Stark physician self-referral legislation on September 5, 2007. As you most likely know, the Stark legislation prohibits a physician from referring a Medicare or Medicaid patient to an entity with which he or she has an ownership interest or compensation arrangement for the performance of certain designated health services (“DHS”). Over the years, CMS has published regulations that have interpreted and expanded upon the existing Stark legislation, and Phase III is the most recent iteration of these rules.

Rather than go into an in-depth explanation of all of the concepts that

were elaborated upon in the Phase III regulations, this article shall highlight some of the key changes that will be applicable to most of the physicians and the health care providers that our Firm represents:

- CMS has provided that a physician now “stands in the shoes” of his or her “physician organization” (such as a group practice) in connection with compensation arrangements that the physician organization has with an entity providing DHS. In most instances prior to Phase III, a physician’s financial relationship through a group practice with a DHS entity would have been an indirect financial relationship, which required a different regulatory analysis. Under the “stand in the shoes” concept, a compensation arrangement between a physician group practice and a DHS entity must meet one of the Stark exceptions for compensation arrangements (such as the personal services exception, fair market value compensation exception, etc.).
- Independent contractor physicians providing designated health services to a group practice that intends to meet the in-office ancillary services exception must provide those services in the



Front row: Jeff, Bill, Dave Back row: Susan, Mike, Karilynn, Leif

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group's facility (subject to the possible exception that may be finalized under anti-markup rules, to be discussed further below). CMS made clear in Phase III of the regulations that

Exception for physician recruitment was modified.

if a group practice wants to have an independent contractor physician satisfy the definition of "physician in the group," the group practice must have a direct contractual relationship with such a physician (and not just the group practice or the entity of which the independent contractor is a member). As such, individual physicians who provide services for a DHS entity contracting with a group practice must be parties to the agreement (or sign a joinder to the agreement in which they agree to its terms).

- "Group practices" under Stark have the greatest ability to distribute productivity bonuses and profits under the Stark legislation. In Phase III, CMS clarified that productivity bonuses can be based on DHS that are provided "incident to" a physician services, but that profit shares could not relate directly to "incident to" services. As such, groups will need to review their existing compensation formulas to make sure that this distinction is incorporated into them and that profits are allocated in a

manner that does not directly relate to the referrals of designated DHS by physicians in the group.

- In the fair market value compensation exception, CMS had previously listed several "safe harbor" compensation methodologies that would be deemed to be fair market value for services rendered. In Phase III, CMS eliminated these "safe harbors" based upon numerous comments to CMS that they were not accurate indicia of fair market value (usually, they produced results that were too low). As such, parties may calculate fair market value using any commercially reasonable methodology that is appropriate under circumstances and satisfies the definition of "fair market value."
- The exception for physician recruitment was modified in a number of aspects, including modifying the requirements related to the areas in which the physician is being recruited to provide services, allowing group practices who employ recruited physicians to impose practice restrictions that do not unreasonably restrict the recruited physician's ability to practice in the geographic area served by the hospital, and loosening the calculation of expenses attributable to a physician only for groups located in a rural area or HPSA that are recruiting a physician to replace a retired, deceased or relocated physician.
- CMS expanded the fair market value compensation excep-

tion to apply to both compensation received by a physician for services provided to an entity providing DHS as well as compensation paid to DHS entities by physicians for services or items received from such entities. CMS also confirmed that the fair market value compensation exception is not applicable to office space rental arrangements.

- The personal service arrangements exception to Stark was expanded to provide a hold-over period of six (6) months following the expiration of the term of an agreement for the parties to enter into a new agreement for providing services if the agreement in question satisfied the personal services exception before it expired. This is similar to the existing holdover provision in the Stark regulatory exceptions for office space and equipment leases.

Following the release of the Phase III Regulations, CMS issued in the 2008 Medicare Physician Fee Schedule ("MPFS")

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final regulations that prohibited the markup of the professional component and technical component of diagnostic tests in certain instances. However, on January 3, 2008, the effective date of these regulations was delayed to January 1, 2009, except that (i) the long-standing prohibition on the markup of the technical component of diagnostic tests still applies and (ii) the new anti-markup rules apply immediately to certain anatomic pathology diagnostic testing services furnished by physician group practices in a centralized building that is not the group practice's main office.

There were many comments made to CMS on the final anti-markup rules in connection with the application of such rules and their impact on physician group practices. Since there may be significant changes to these rules prior to January 1, 2009 (and the current applicability of such rules is limited to certain anatomic pathology services), I will not provide an in-depth analysis of these rules in this article. In sum, however, the basic tenets of the anti-markup rules would prohibit a physician practice from marking up the technical component and professional component of any diagnostic tests ordered by a billing physician or other supplier if the technical component or professional component is purchased outright or if the technical component or professional component is performed at a location other than the office of the billing physician or other supplier. There are many issues with the anti-markup rules, such as the definition of the "office of the billing physician or

other supplier" not being consistent with the requirements of the Stark regulations as to the provision of DHS. In fact, under the anti-markup rules that will become effective (unless modified) on January 1, 2009, services provided by a group practice off-site in a "centralized building" may not meet the anti-markup rule requirements, and as such the group practice may be viewed as "purchasing" the technical component or professional component of a diagnostic test even though it actually performs the test itself. There are also concerns with the final rules in connection with the manner in which a group practice would actually calculate the "net charge" of a technical or professional component that is "pur-

chased" by the physician group.

It is uncertain at this time as to whether the anti-markup provisions will be implemented in their current form or modified to respond to industry comments before they are finalized. While it is likely that these rules will not become effective in their current form given the large number of comments that CMS received on them, it is wise for health care providers to pay close attention to what happens in this area as it could have a significant impact on the operation of their practices on January 1, 2009. If you have any questions with regard to how the anti-markup rules or the changes to Stark promulgated in Phase III effect you or your entity, please feel free to contact me. ■

New Jersey passes state False Claims Act

By Karilynn Bayus, Esquire

This January, New Jersey Governor John S. Corzine signed into law the New Jersey False Claims Act ("NJFCA"). The legislation became effective sixty (60) days after its enactment.

The Act is substantively similar to the federal False Claims Act. The need for a state act in addition to the federal arises from the fact that the federal act only deals with claims presented to the federal government. For a program such as Medicaid, which is administered by the states, claims may not necessarily go directly to the federal government, thus sometimes presenting a "loop-hole" in the federal act.

The NJFCA, like the federal statute, is broad in nature and addresses false claims outside the health care field realm. The New Jersey Act, however, contains many provisions dealing expressly and exclusively with false claims submitted to the state for payment under the Medicaid program.

With the enactment of the Act, New Jersey follows suit in an emerging trend of state-enacted False Claims Acts.

Details of the Act

The NJFCA makes it illegal to, among other things, "knowingly present or cause to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State

funds, a false or fraudulent claim for payment or approval.” Acts which occur by “innocent mistake” or by “mere negligence” are not punishable under the Act. The civil penalties to be assessed for

An action under the statute may be initiated by the New Jersey Attorney General or by a private citizen

such a violation are not to be less than those under the federal FCA. A court may reduce the treble damages to not less than twice the amount of damages sustained by the State if certain factors are met.

Provisions of the NJFCA allow for penalties for submission of claims which are submitted in violation of the Act. There are numerous standards for illegal submission of a claim.

Specific to Medicaid, the Act amended the NJ Medical Assistance and Health Services Act to make it illegal to willfully receive benefits, greater than that to which one is entitled for medical assistance payments. Violation of this provision subjects a person to criminal liability of a “high misdemeanor” punishable by fines and/or up to three years imprisonment. Violators are also subject to civil penalties.

An action under the statute may be initiated by the New Jersey Attorney General or by a private citizen on behalf of the state government. When brought by a citizen, the action is known as a *qui tam* action. Certain citizens are not permitted to bring civil actions, such as state employees who dis-

cover wrongdoing as a part of their regular job description. In a *qui tam* action, a complaint will be held under seal for at least 60 days before the court will order the complaint served on the defendant. The New Jersey Attorney General will have the option, upon filing of the complaint, to decide whether to intervene or not.

If the Attorney General opts to intervene, and the suit is successful, the citizen will receive between 15 and 25 percent of the proceeds recovered. The Attorney General receives a fixed rate of ten percent, which goes to a “False Claims Prosecution Fund” to fund later investigations. The Fund was also created by the NJFCA. If the Attorney General does not intervene, and the citizen is successful, the citizen is entitled to between 25 and 30 percent of the recovery. If a citizen is entitled to a recovery, he or she will also be awarded attorney’s fees, expenses and costs.

For Medicaid false claim actions, twenty five percent of the State share of recovery will be deposited into the “Medicaid Fraud Control Fund.” The Medicaid Fraud Control Fund was established previously under the NJ Medical Assistance and Health Services Act (the Act controlling the New Jersey medical assistance program). Money in this Fund is used for the exclusive purpose of investigating and prosecuting Medicaid fraud.

The Act contains further “whistleblower” protections for employees making disclosures pursuant to the NJFCA. Employers may not create any policies preventing employees from mak-

ing disclosures to the state in furtherance of a false claims action. In addition, employers may not take adverse employment action upon an employee who makes such a disclosure. Employers found to be in violation of this provision face reinstating the employee, paying double the back pay owed to the employee plus interest, compensation of the employee’s special damages, potential punitive damages, and mandatory payment of the employee’s court costs and reasonable attorneys’ fees

The NJFCA further enumerates administrative repercussions for violations. If a licensed professional, or his or her agent or employee, is found to be in violation of the Act, the New Jersey Attorney General will notify the licensing board of the violation.

If a licensed professional...is found to be in violation of the Act, the New Jersey Attorney General will notify the licensing board of the violation.

Conclusion

It remains to be seen whether the passage of the NJFCA will be a catalyst in New Jersey for increased Medicaid fraud prosecution.

Pennsylvania does not currently have a state False Claims Act. As enacting such laws seems to be a developing state trend, we will be watching to see if such an Act comes into effect in Pennsylvania. ■

Be sure your manager has time to manage

By Dorothy R. Sweeney*

One of the most difficult positions in a medical office is that of the manager of a small to mid-sized group practice. A practice that is not large enough for a “high level” Administrator still requires a level of management expertise and attention. But, the manager of a smaller practice often gets so caught up in the day-to-day activities and putting out fires, that s/he doesn’t always have the time to step back and look at how things are being done. These managers often tell us that they want to institute changes to make the practice function more effectively, but taking that time out of a busy day just doesn’t happen. So, “the way we have always done it” remains, often resulting in doctor dissatisfaction and office inefficiency.

A manager needs to manage. And, that means s/he needs to take time to institute changes in business systems and routines to make the practice work smoother. Given the economies of a medical practice today, it also means critically reviewing the use of staff since your expense for personnel can range from 18% to 27% of a practice’s gross receipts, depending on the specialty. That is a large dollar amount. You need to use it wisely.

If this is your manager (or you are that manager) it is time to reassess priorities to function in a leadership role. Here are some suggestions for the manager in dealing with job duties.

Review the manager’s job description

A manager should first review his/her own job description. All

positions in a medical practice should have written job descriptions that are updated and revised periodically (ideally once a year). Realistically, a manager’s job description is one that evolves, particularly if s/he has been in the job for awhile. Have your manager critically review the broad categories of job duties (personnel management; business systems; finances; computers; marketing) and then under each category list the major areas of responsibility.

A job description is not a procedure manual. It should not list how something is done, but rather it spells out areas of responsibility. For example, here is a sample of the personnel duties from a job description developed recently for the manager of a three doctor specialty practice.

Personnel

- Ultimate responsibility for all office staff, including hiring, firing and supervising. Responsible for all non-clinical aspects of back office staff.
- Handle salary review and adjustments. Primary responsibility (with physician input) on employee evaluations.
- Maintain control of all personnel records, including vacations, sick days and personal days. Arrange coverage for all staff as needed.
- Organize regular staff meetings, set agendas and follow-up to assure approved changes are actually implemented.
- Determine and change personnel assignments and job descriptions as needed.

Notice that these broad categories indicate that the manager makes things happen. S/he makes sure that the right people are hired; trained; supervised and compensated appropriately. Communication skills are essential and the manager is the “go to” person to make changes as necessary. As a practice expands a manager also needs time to be available to staff and to physicians. S/he need that time to be available and thus should not be scheduled so tightly that the staff feels she is not accessible.

What should a manager not handle

As importantly, look at what your manager handles routinely that could and should be delegated to someone else. For example, the manager of a small specialty surgery practice never seemed to have time to delve into the practice finances and statistical numbers. The doctors felt that their practice numbers, particularly new patients, were off and they wanted her to really look at the patient numbers. Were new patient numbers down, did some referral relationships need to be repaired and was the practice timely scheduling new patients? They had heard vague comments of dissatisfaction. They needed answers before things got more out of control.

And, she kept saying she wanted to delve into the accounts receivable which seemed to be taking a longer time to collect. She was frustrated because she was working longer hours yet not accomplishing what needed to be

done. The doctors were beginning to question her ability to perform in the managerial role.

In analyzing how this manager spent her time and her workflow, it was found she was also responsible for handling some of the doctors' dictation/correspondence. Routine correspondence was handled by another staff member, but she hung on to some of the special letters to referring doctors both because "she always did it" but also because she enjoyed the comfort of the old clerical routines. When specifically asked why she kept these duties, knowing they were truly not "managerial" she admitted it gave her a chance to escape back to old routines that she enjoyed handling for a number of years.

Managers need to get out of their comfort zone. Upgrade the duties to focus on what will make a manager more valuable to the practice and the physicians. A manager needs time to deal with staff; to interact with patients and to understand and analyze the practice finances; to work with billing employees on insurance matters and delinquent accounts and to offer ways to make the practice more accessible to patients. S/he needs to keep up-to-date on technology so that the practice can use computers and technology to become more effective. A manager cannot handle all these items if bogged down with clerical items that could be delegated to another employee. And, from a cost saving standpoint, your manager commands the highest salary in the practice. Routine work should be handled by a lower paid employee.

How to upgrade your manager

You want to keep your manager in your practice, and often we are asked how someone who has been in that role for a number of years can upgrade his/her responsibilities and attitude about the position. Here are a few suggestions:

1. A manager needs to have someone to whom s/he can directly report. In a group practice that is often difficult if one physician is not given the responsibility as the managing doctor. As a group, decide who should be the doctor the manager reports to. Ideally it would be one doctor, but if that is not a workable situation, assign specific areas of responsibility to individual physicians (for example, one doctor is in charge of personnel; another in charge of finances, etc.). The worst possible scenario would be for the manager to have to report to all doctors on all things. That will absolutely guarantee a "no win" situation for the manager.
2. Encourage your manager to join a manager's group in your area. Investigate which is the most appropriate for your situation – it might be the Medical Group Management Association; it might be a local manager's group or it may be the manager's section of your specialty practice association. The educational sessions are important, but so are the working relationships that develop with others in the same positions in other practices. Often these relationships help the manager focus on ways to improve jobs

in the practice since they bounce ideas off each other.

3. Look at ways the manager can also educate himself/herself in technology to improve how the practice operates more effectively. There are so many areas in the practice operations where technology can be used to cut down the need for additional staff; to make daily routines work more smoothly and to assure that a practice is looked at as being on the "cutting edge." And, as the insurance industry requires more electronic requirements, your finances are affected if you do not keep up-to-date. Once the manager investigates different forms of technology, s/he needs to do a cost analysis to determine if there is a benefit to making changes. All this takes time.
 4. Give feedback to your manager as to how s/he is handling her role. Use the revised job description as the tool in evaluating a manager's job responsibilities. Keep track of any special projects assigned to the manager and if those projects are completed satisfactorily. Look at not only specific duties, but also the morale in the office and the tone that the manager has set with the employees. In order to hold the manager responsible, routine and constructive feedback is important. Give specific timelines on projects and hold the manager accountable.
- It is not always easy to change the mindset of the manager of the physicians in developing a new management structure. This is especially true if a manager has

been on board for a number of years, but is now being challenged to fill a more upgraded managerial role. Oftentimes it is easier to make this happen with a new manager coming on board. But, with diligence on both the part of the manager and the physicians, it can become a more effective working management team. Give your manager time to manage your practice and allow him/her to step away from the comfort level of “the way we always did things” to make your practice more effective. It will be a “win-win” situation for all concerned. ■

** Ms. Sweeney provides practice management consulting services for our clients through our related consulting practice, Professional Practice Consulting, Inc.*

Retirement plan update

By Jeffrey B. Sansweet, Esquire

There is good news once again for doctors in the retirement plan area. Cost-of-living adjustments have increased the maximum allowable pension and/or profit sharing plan annual contribution from \$45,000 to \$46,000 for plan years beginning in 2008. The annual compensation which may be taken into account in computing one's contribution has also increased from \$225,000 to \$230,000 effective with plan years beginning in 2008. For those practices that have a “permitted disparity” feature in their plans, these changes mean that the practice may contribute an additional \$1,000 in 2008 for the physicians with only a very slight increase (.058%) in the contributions for the typical staff person. For those

Billing Medicare beneficiaries for missed appointments

By Vasilios J. Kalogredis, Esquire

We are often asked whether Medicare patients may be charged for missed appointments.

CMS clarified things on October 1, 2007. CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment

and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly. ■

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of you with 401(k) plans, the annual elective deferral limit for 2008 is still \$15,500, and if you are at least age 50 by the end of the plan year, an additional “catch-up” 401(k) contribution is allowed up to \$5,000 in 2008.

The not-so-good news is that for defined contribution plans which allow for participants to direct their investments, the Department of Labor now requires a quarterly benefit statement be provided to each participant by no later than 45 days after the end of each quarter. The statement must include the participant's account balance, vested percentage, explanation of permitted disparity if applicable, any investment restrictions, diversification information and the DOL website for investment information. ■



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Jeffrey B. Sansweet spoke at the American Academy of Ophthalmology Annual Meeting on November 11 and 12, 2007 in New Orleans on Employment Agreements and Partnership Deals. Jeff also presented a course on March 12, 2008 at the

University of Pennsylvania School of Dental Medicine on Employment Contracts.

Bill Kalogredis spoke to the American Academy of Cardiology-Pennsylvania Chapter at its annual meeting on October 12, 2007 on Contracts. On October 21, 2007, Bill spoke to practicing dermatologists at the Clinical Dermatology Conference in Las Vegas on "Five Legal Tips." Bill spoke in Philadelphia at the American Epilepsy Society Meeting on November 30, 2007 on Employment Contracts and Running the Medical Practice as a Successful Business. He also presented in San Antonio at the American Academy of Derma-

tology Practice Management Symposium on January 31, 2008 on Employment Agreements, Negotiation Tips, and Five Practical Tips. Bill has also been authoring a monthly article on healthcare law for the Legal Intelligencer, the oldest law journal in the country. Bill has authored an article for an upcoming issue of *Physician's News Digest* on "Do You Need a Contract When a Doctor Leaves a Practice?"

Michael Burke will have articles on "Understanding Physician Employment Agreements" and "Buying into a Medical Practice" published in upcoming issues of M.D. News.