



A summary of recent developments provided by the health care law firm **Garfunkel, Wild & Travis, P.C.**

Insurance Companies to Use Medicare Reimbursement Schedules as Basis for Paying Out-of-Network Providers

The Department of Banking and Insurance (DOBI) has proposed amending the rules governing out-of-network reimbursement by specifically allowing carriers to use the Resource Based Relative Value Scale used by the Centers for Medicare and Medicaid Services as the basis for payment of out-of-network non-hospital provider claims (i.e., the Medicare Fee Schedule). This practice is not currently prohibited by state law. Carriers include insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefits plans in New Jersey, as well as dental service corporations and dental plan organizations authorized to issue dental plans in New Jersey.

The proposed ruling allows carriers to use a multiple of the Medicare Fee Schedule of *no less* than 150 percent of the Medicare rate. According to the rule proposal, the 50th percentile of Prevailing Health Care Charges System (PHCS) corresponds to approximately 175 percent of the Medicare rate and the 80th percentile of PHCS corresponds to approximately 225 percent of the Medicare rate.

The commentary to the DOBI proposal states: "Providers will continue to have the opportunity to collect from

members or covered persons the difference between their billed charges and the amounts carriers pay as benefits." The proposed rule would also lower the maximum coinsurance percentage for out-of-network benefits from 50 to 40 percent. DOBI has extended the comment period on this proposed regulation to May 2, 2007. ■

Employees Must Now Be Notified of Changes in Health Benefits

According to a new rule adopted by the New Jersey Department of Labor and Workforce Development, all employers, regardless of the size of their workforce, must notify employees of any change to or termination of an employer-sponsored health benefits plan.

Effective January 16, 2007, an employer must now not only deliver

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Proposed Bill Requires Carriers to Make Disclosures to Participating Providers

The New Jersey Assembly recently proposed legislation that would mandate carriers to disclose specific information to health care providers who contract with them. The legislation would also require carriers to obtain health care provider approvals prior to certain contract modifications.

Introduced on January 9, 2007, by Assemblyman Neil Cohen, this bill (A3881) provides the health care provider with the opportunity to review any proposed contract, as well as the right to review internally generated carrier documents relating to policies, procedures, protocols, quality assur-

ance and utilization. This applies for the duration of the contract.

The bill also provides the health care provider with the necessary procedures to request and approve contract changes (which cannot occur unilaterally), specific contract duration terms and prohibitions on automatic renewals (unless separately agreed to by the parties in writing). The bill guarantees that the contract would continue should the carrier merge or consolidate.

This proposal enhances the rights of the health care provider, while limiting the rights of the carriers. There is no similar bill in the New Jersey Senate at this time. ■

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Cardiac Gainsharing Program Approved by OIG

On November 17, 2006, the Office of the Inspector General (OIG) released an advisory opinion approving a cardiac surgery gainsharing program. The cardiology group that submitted the request received a favorable response with the OIG determining that while the arrangement may violate the Social Security Act and the anti-kickback statute, the OIG will not impose sanctions. The OIG did not analyze the arrangement for compliance with the Stark Physician Self-Referral Law, as it falls outside the scope of the OIG's advisory opinion authority.

The key elements of the gainsharing program include "open on use" or "use

as needed" policies. This is targeted at reducing the waste of unused operating room supplies that have been opened in advance and limiting the use of certain drugs to cases in which they are shown through benchmarking studies to be medically necessary. Other elements include the substitution of less costly items for those currently being used by surgeons, such as reusable hyperthermia blankets, gel pads and ace bandages. The arrangement would pay the surgeons 50 percent of the savings realized through implementation of cost reduction measures for a period of one year.

The OIG maintains that this opinion is consistent with the 1999 Special

Advisory Bulletin that found gainsharing arrangements generally in violation of the anti-kickback statute. ■

Proposed Safe Patient Handling Act Would Reduce Risk of Injury

The Safe Patient Handling Act, a bill proposed by the New Jersey Assembly, would establish a program to reduce the risk of injury to both patients and health care workers at health care facilities. Under this Act the following health care facilities would be required to establish programs for safe patient handling practices: general and special hospitals, nursing homes, state developmental centers, and state and county psychiatric hospitals.

Specifically, the Act would require facilities to:

- Establish a safe patient handling program within 36 months of enactment of the Act.
- Establish a safe patient handling policy, including a statement concerning the right of a patient to refuse assisted patient handling. (Assisted patient handling involves the use of mechanical equipment. This includes, but is not limited to, electric beds, portable base and ceiling track-mounted full body sling lifts, stand assist lifts, mechanized lateral transfer aids and patient handling aids.)
- Post their safe patient handling policy in a location visible to staff, patients and visitors and designate a facility management representative to oversee the program.

On January 18, 2007, the Assembly bill was referred to the Assembly Appropriations Committee. There is currently an identical bill (S1758) in the New Jersey Senate that was referred to the Senate Budget and Appropriations Committee on December 14, 2006. ■

DHSS Proposes Four Additional Immunizations for Children

The Department of Health and Senior Services (DHSS) proposes the addition of four immunization requirements for school age children. The recommended vaccines are influenza (flu), pneumococcal conjugate (pneumonia), meningococcal conjugate (meningitis), and a booster of tetanus, diphtheria and acellular pertussis (Tdap). This follows approval of the vaccines by the Federal Drug Administration, the U.S. Dept. of Health & Human Services Centers for Disease

Control and Prevention, the Academy of Pediatrics and the Academy of Family Physicians.

This ruling will not require any additional office visits above regular checkups. Of the four proposed additional immunizations, the pneumonia and flu vaccines would be given while a child is in preschool or in childcare and the meningitis and Tdap vaccines upon entering sixth grade. ■

Employees Must Now Be Notified *Continued from page 1*

notice of any change or termination of coverage to each employee, but must also have verifiable proof that delivery occurred. Employees must be informed of any changes the day after the employer receives notification from the health insurer.

If the employer is going to stop

coverage, he or she is required to inform his or her employees at least 30 calendar days prior to the date coverage is to end. The penalty for failing to comply with this regulation is \$200 per employee covered by the health benefits plan. ■

Sanitation in Food Establishments

The DHSS adopted a new rule effective January 2, 2007, that imposes sanitation requirements on Risk Type 3 Establishments that serve food — including hospitals and nursing homes — as the people they serve are highly susceptible to infection. A “Risk Type 3 Food Establishment” is defined as “a facility that has an extensive menu and requires the handling of raw ingredients.”

The new rule requires that such facilities have a designated “in charge” person present during all hours of operation. Also, the establishment must have one employee certified in a food protection program that is accredited by the Conference for Food Protection. Each establishment will be required to meet the certification requirements within three years.

Supplemental Newborn Screenings

The DHSS has adopted the Newborn Biochemical Screening Program that provides specific procedures and requirements for testing newborns for certain metabolic disorders.

Effective February 5, 2007, health care providers must now provide all expectant parents with a pamphlet that advises them of the availability of supplemental newborn screenings which are in addition to the 20 disorders already tested by the state. While there is no charge for the screening of initial disorders tested by the state, parents must pay out of pocket for any supplemental testing as additional screenings are handled by private laboratories that

parents must locate on their own.

Testing must be completed several months prior to the expected delivery date as timely intervention can lead to a significant reduction of morbidity, mortality and associated disabilities (such as mental retardation) in affected infants.

It is the health care provider's obligation to provide this pamphlet and to answer any questions that the expectant parent may have. In addition, the health care provider must maintain the original signed document that acknowledges the expectant parents receipt of the pamphlet in connection with the option for additional testing.

Clinical Lab Improvement Service

Effective January 9, 2007, the DHSS Public Health Services Division of Public Health and Environmental Laboratories adopted new rules regarding the requirements for clinical laboratories in New Jersey. While generally consistent with the federal standards established under the Clinical Laboratories Improvement Act of 1967 and the Clinical Laboratory Improvement Amendments of 1988, the new regulations impose some additional standards as follows:

- A clinical laboratory director must spend adequate time on the laboratory's premises.
- An individual cannot serve as director of more than three laboratories. (The federal government permits an individual to serve as director of up to five laboratories.)
- A general supervisor must be on the laboratory premises during normal

hours of operation. (The federal government requires a supervisor to be onsite only when a highly complex test is performed.)

- A general supervisor must have a Bachelor of Science degree, plus six years of laboratory experience. (The federal government requires a general supervisor to have an Associate degree, plus two years of laboratory experience.)

- Laboratories must report various hazardous substances and communicable diseases to state and local health agencies. (The federal government does not have any similar provision.) ■

Hospital to Pay Estate of Patient Who Committed Suicide

In a recent New Jersey medical malpractice court decision, an arbitrator awarded \$750,000 to the estate of the deceased patient. The case involved a former psychiatric patient who may have committed suicide because the psychiatric hospital treating him inappropriately pressed him over his finances.

The complaint stated that the hospital staff failed to properly clear the patient's expenses with his health insurance company after he was discharged and, as a result, the staff repeatedly contacted him about his ostensible “insurance problems.” A few hours after one such call, the patient committed suicide.

The former patient was a high-powered engineer who became depressed because of a long layoff. ■

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Proposed Bill Regulates Access to Carrier's Documents by Health Care Provider

The New Jersey Senate recently proposed a bill to regulate the disclosure and use of privately negotiated in-network fees and reimbursement rates. A confidentiality and non-disclosure statute, the bill also prohibits the disclosure of contracted rates to non-parties.

Under the bill, a carrier would not be permitted to disclose the terms or conditions of a plan to a third party, except for the purpose of administering a health insurance plan or providing an insured person an incentive to utilize the network for a covered service. The restrictions on disclosure would also apply to any third party administrator or billing service for the carrier.

Additionally, the bill would prohibit a person or entity (other than a carrier), organized delivery system, third party administrator or billing service from disclosing any predetermined fees or reimbursement rates to any health care provider in any network.

Finally, the bill prohibits a carrier, organized delivery system, third party administrator, or billing service from calculating the reimbursement rate of any out-of-network health care provider by using any negotiated predetermined

fee or rate agreed to by any health care provider in any network. Violation of the act would result in an order to pay restitution to any aggrieved person and liability for civil penalties of not less than \$500 and not more than \$10,000 for each violation. The Senate proposal reduces access to information by limiting the disclosure of contract information to third parties. ■

Changes to Living Arrangements Aired

The Department of Human Services, Division of Developmental Disabilities, held public hearings in January 2007 to obtain public input on a plan to move individuals from institutional living to community living arrangements.

This plan is in response to a lawsuit filed by New Jersey Protection and Advocacy with the aim of depopulating New Jersey's Developmental Centers. However, the plan will only affect those residents of Developmental Centers who express a desire to live in the community and whose individual habilitation plan so recommends. ■

Final Ruling on Physician Members of LLCs

Pursuant to N.J.A.C. 13:35-6.16(f), the New Jersey Board of Medical Examiners has denied a request that the Petition for Rulemaking be amended to allow physicians who are not licensed in New Jersey to become members of a New Jersey Limited Liability Company conducting business as a medical practice. Thus, it remains mandatory that a physician be licensed in New Jersey in order to become a member of a professional medical limited liability company in the state. ■

Tax Deductions for Practicing within HEZ

Effective January 10, 2007, the Department of Treasury, Division of Taxation, has adopted a new rule regarding the availability of tax deductions for taxpayers who provide primary care in a "Health Enterprise Zone" (HEZ). An HEZ is a municipality that has been designated as an underserved area by the DHSS.

Primary care includes, without limitation, general internal medicine, general dentistry and other similar areas. To qualify for the tax deduction, a practitioner must practice in an HEZ or within five miles of an HEZ. ■

About Garfunkel, Wild & Travis, P.C.

Garfunkel, Wild & Travis, P.C. (GWT) is among the most active health care specialty law firms in the country, with offices in New Jersey and New York. It serves numerous New Jersey hospitals, licensed health facilities, medical practices, physicians and other health care practitioners, and health care related companies.

The firm specializes in addressing the complex legal, regulatory, business and financial needs of its clients: it helps clients negotiate favorable reimbursement rates from insurers and government; gain regulatory approval for facilities expansion or new services; merge, acquire or network with other organizations; and purchase or lease new technology and equipment. GWT also assists numerous health care providers and others to comply with complicated, costly, and often onerous state and federal regulations.

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Proposed Ban on Med for Sex Offenders

The New Jersey Department of Human Services has proposed a ruling that would exclude coverage for erectile dysfunction medication for individuals listed on the state's Sex Offender Registry. This would affect only those individuals covered by Medicaid or NJ FamilyCare. The federal government does not provide funds to cover erectile dysfunction, rather the drugs are paid for exclusively with state funding. ■