



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

## N.J. Passes Claims Denial/Prompt Pay Law

Health care providers can soon focus more on their patients thanks to a new claims denial/prompt pay law that sets out specific guidelines for health insurance providers regarding authorizing the delivery and payment of health care services. Recently enacted and effective July 11, 2006, the Health Claims Authorization, Processing and Payment Act provides a more streamlined process for approvals and reimbursements. The main provisions of the act are:

- **Deadlines for Payment Denials.** For prior approvals of inpatient hospital services, or services rendered on an outpatient basis, the payer must notify the health care provider of a denial within 15 days. In the case of an authorization request for an insured person currently receiving inpatient services, a denial or limitation of the request is required within 24 hours.

If additional information is necessary, a request for extension is also required within 24 hours. If the payer fails to respond within this time frame, the service will be deemed approved with the payer responsible for payment. If the health care provider fails to respond to a request for additional information within 72 hours, the request for authorization will be deemed withdrawn.

- **Reimbursement of Covered Services.** A payer cannot deny reimbursement for a covered service on the grounds of medical necessity if the service was pre-authorized or the payer failed to respond to a request for autho-

rization. Also, if a health care provider received authorization from a payer and the patient switches payers, the subsequent payer is required to reimburse the health care provider. If a health care provider determines that a patient should be discharged to an alternate facility, the payer must cooperate with that plan.

- **Information on Payment Policies.** Payers must provide, via an Internet website, information regarding their utilization management and claims processing and payment policies. All changes must be posted for 30 days before becoming effective.

- **Internal Appeals Process.** Payers must establish an internal appeals process regarding benefit determinations. In the case of such an appeal, if

the payer decides favorably for the health care provider, the payer must submit payment for any amounts so decided within 30 days of the decision, with accrued interest at 20 percent.

Payers violating the act can be fined between \$250 and \$10,000 for each day they are in violation. If the payer decides against the health care provider, the payer must give notification of its finding within 10 days following receipt of the appeal form. Any disputes regarding internal appeals will be submitted to arbitration.

- **Consent to Appeal.** Health care providers are authorized to appeal benefit determinations for a patient with their consent, with the health care

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## Prevailing Wages Required For Construction of Facilities

A new regulation, effective November 21, 2005, requires that prevailing wages be paid to workers fulfilling construction contracts greater than \$2000 for recipients of assistance from the New Jersey Health Care Facilities Financing Authority (HCFFA). This includes contracts, sub-

contracts or agreements for construction, reconstruction, renovation, demolition, alteration, repair work, maintenance work related to a project or construction related to the installation of equipment for any medical provider.

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New Jersey Health Law Bulletin is written and edited by Jeffrey S. Brown, Andrew E. Blustein, Steven R. Antico, Alan H. Perzley, and Rebecca A. Edelman of Garfunkel, Wild & Travis, P.C., Hackensack, NJ. Reader questions are welcomed; the editors can be contacted at 201-883-1030.

# CMS Scrutinizes Directorships In Long-Term Care Facilities

Every nursing home must have a designated medical director who is knowledgeable about current standards of practice and plays a pivotal role in providing clinical leadership according to new interpretive guidelines recently issued to the online State Operations Manual by the Centers for Medicare and Medicaid (CMS). These guidelines are in response to the 2001 Institute of Medicine report, "Improving the Quality of Long Term Care," which urged facilities to give broad authority to medical directors.

According to the guidelines, the medical director is responsible for developing and reviewing procedures and guidelines that ensure the facility is abiding by current standards of practice and addressing the needs of its residents. CMS provides a non-exclusive list of policies that medical directors of long-term care facilities should work to implement, such as admission policies, integration of delivery of care and services, use and

availability of ancillary services, and end-of-life care policies.

CMS stresses that a medical director is responsible for coordinating care that supports the needs of the facility's residents, that is consistent with current standards of practice, and that helps the facility meet its regulatory requirements. Coordination of care includes ensuring that residents have primary attending and backup physician coverage, developing a process to review basic physician and health care practitioner credentials, and addressing and resolving issues regarding conflicts between physicians and staff or continuity of care and transfer of medical information.

To receive a positive CMS audit and abide by current fraud and abuse laws, compliance officers should ensure that their facility's policies regarding medical directors comply with the standards set in the guidelines. While CMS only addressed long-term care facilities, it is likely the guidelines will apply to all facilities. ■

## ***N.J. Supreme Court Affirms Ruling on Insolvent Insurers***

The New Jersey Appellate Division overturned a precedent that had prohibited holding an insured person liable for damages in excess of the \$300,000 maximum under the Property-Liability Insurance Guaranty Association Act (PLIGA) (when an insurer became insolvent).

The New Jersey Supreme Court affirmed the ruling, while noting the potentially disastrous effect it may have on responsible citizens and instructed the state legislature to take

appropriate action to remedy this problem.

This decision has serious liability ramifications for all professionals carrying malpractice insurance in the event their insurer becomes insolvent. The case, *Johnson v. Braddy*, was a personal injury action against a truck driver and the driver's employer for damages in excess of the maximum allowed under PLIGA. ■

## ***Prevailing Wages Required For Construction of Facilities***

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According to the regulation, the general contractor must apply (or have each subcontractor apply) to the New Jersey Department of Labor and Workforce Development for a wage determination and must specify in the contract the rate to be paid for each trade. In addition, the general contractor and each subcontractor must file all required reports and keep all records for two years from a project's completion date. They must also permit the Department and other interested parties complete access to all records required.

All recipients of assistance for construction projects must provide the HCFFA with a certificate at the completion of a project ensuring that the recipient has complied, as have the contractors and subcontractors with the requirements of N.J.A.C. § 8:95-1.2 or that the recipient has not entered into any construction contracts subject to the provisions of this code.

For non-compliance, the Department can assess administrative penalties on the provider up to \$2500 for a first violation and up to \$5000 for subsequent violations. It can also refer the matter to the state Attorney General for investigation and prosecution.

Any provider who delays the commissioner of the department in the performance of his enforcement duties by failing to keep required records, falsifying records, or refusing to make records accessible is guilty of a disorderly persons offense. Violators can be fined from \$100 to \$1,000 or be imprisoned from 10 to 90 days – or both. Each week, any day of which a worker is paid less than the rate applicable to him, constitutes a separate offense. ■

### IPF Payment Increase

In-patient psychiatric facilities (IPFs) may receive an average 4.2 percent increase in their Medicare payment rates beginning July 1, 2006 due to a proposed update to Medicare IPF payment rates for discharges proposed by CMS. The proposed rules also include a new method of determining IPF inflation, a new basis for determining wage index adjustment, an increase in the fixed dollar loss threshold amount for outlier payment, an increased payment for electroconvulsive therapy and various changes in coding and DRG classifications.

### Fee Schedules Required

A New Jersey law recently enacted and effective May 9, 2006, requires all insurance carriers offering a managed care plan to supply health care providers, on request, with a written or electronic fee schedule. The fee schedule must include the fees for the 20 most common evaluation and management codes and the 20 most common office-based or hospital-based in-network services for the provider's specialty. The schedule must be provided within 15 days of a request by a provider.

### RADs Reclassified

Medicare beneficiaries will have lower out-of-pocket expenses for use of certain respiratory assist devices (RADs) thanks to a final ruling by the CMS declassifying the devices as durable medical equipment (DME). RADs with a timed backup feature will be classified as capped rental DME effective April 1, 2006.

### Practice Structure Regulations

The New Jersey Board of Medical Examiners (BME) announced that it is considering a petition to amend the professional practice structure regulations to allow physicians licensed in another state and *not* in New Jersey to become a member of a New Jersey Limited Liability Company (LLC). The proposal would not allow the physicians to control a majority of the membership interest in the LLC or to practice medicine in New Jersey.

### Medical License Suspension

Any physician whose license has been revoked by another state, agency or authority will have their license suspended in New Jersey by the BME per a law adopted by the New Jersey State Assembly (Bill A-1698) on January 4, 2006.

### Reporting Malpractice Settlements

Effective November 21, 2005, all medical malpractice insurers in New Jersey must report award payouts to the state Commissioner of Banking and Insurance. This includes any settlement, judgment or arbitration award regardless of whether the practitioner is currently insured by the insurer at the time of payout. The notification must contain the specialty or practice area of the practitioner, the amount of the pay out, and any other information required by the Medical Practitioner Review Panel. The identity of the practitioner need not be disclosed.

### Emergency Health Powers Act

Discussed previously in the *New Jersey Health Law Bulletin*, the Emergency Health Powers Act is an

extensive measure that delegates broad authority to the state Department of Health and Senior Services (DHSS), including the authority to create a registry of health care workers within the state who are qualified and willing to volunteer their services in the event of a public health emergency. All volunteer health care professionals receive civil immunity and, in some cases, compensation and/or reimbursement for services or property employed during an emergency. The law also directs DHSS to develop a vaccine prioritization plan and compile vital statistics. It became effective on September 14, 2005. ■

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provider bearing all costs associated with the appeal. Patient consent can be obtained or revoked at any time.

● **Claims Containing Technical Errors or Missing Data.** If a claim received by a payer contains technical errors or is missing data, the payer must electronically notify a health care provider within seven days. On receipt of the correct data, the payer must pay the claim or notify the provider of nonpayment within 30 days.

● **Medical Necessity.** Disputes regarding medical necessity determinations can be submitted to the Independent Health Care Appeals Program (IHCAP) under the Department of Health and Senior Services.

● **Underpayments and Overpayments.** Except in cases of fraud, a payer can only seek reimbursement from a health care provider for overpayments within 18 months following payment. The same holds true for a provider seeking payment from a payer. ■

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# GWT Recognized for ‘Financing Deal of the Year’

*The M&A Advisor*, a leading mergers and acquisitions newsletter, recently recognized the \$250 million recapitalization of Diagnostic Imaging Group, a network of diagnostic imaging centers in New York and Florida, as the “Financing Deal of the Year.” GWT, along with an investment banking firm and a private equity firm, conducted the transaction. *The M&A Advisor* recognized the team for demonstrating outstanding innovation and perseverance in structuring and concluding an

especially challenging transaction.

According to *The M&A Advisor*, nine out of 10 M&A deals never go to contract, so it is especially fitting to recognize the achievements of those firms whose persistence, drive, imagination and courage result in deals that are successfully concluded. The annual M&A awards were determined by an impartial committee made up of the editorial staff of *The M&A Advisor* and other business reporters and writers, as well as professors of finance from

leading universities.

The announcement was made at a banquet that followed the conclusion of *The M&A Advisor’s* annual national conference and was attended by luminaries of middle market investment banking, financing, and private equity, as well as experts in the legal, accounting and investigative fields. ■

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## ***Steven R. Antico Authors Corporate Governance Article***

GWT partner Steven R. Antico recently published a comprehensive article detailing the duties of the board of trustees and/or directors of a health care organization. Featured as the cover article in the Dec. 2005 issue of the *New Jersey Law Journal Health Law Supplement*, it urges board members to keep pace with changing nonprofit governance principles. Mr. Antico specifically warned boards that legislative and agency intolerance of board impropriety and inaction will mean heightened scrutiny of nonprofit boards by attorneys general and the Internal Revenue Service.

Mr. Antico is a member of GWT’s Health Care, Corporate, and Tax Practice Groups. With over 10 years experience in the health care field, Mr. Antico specializes in corporate law, health and regulatory structuring and analysis, business succession planning and tax analysis. The full text of his article can be found at [www.gwtlaw.com](http://www.gwtlaw.com). ■

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## **Alan H. Perzley Is Noted Speaker At Seminar on Real Estate Closings**

GWT senior attorney Alan H. Perzley was one of three noted speakers at a recent seminar entitled “Fundamentals of Real Estate Closings in New Jersey” in East Brunswick.

Topics Mr. Perzley addressed included preparing contracts for commercial purchase or sale, commercial real estate transactions and due diligence, and

events at a commercial closing.

A member of GWT’s Finance and Real Estate, Business and Health Care Practice Groups, Mr. Perzley advises clients on a variety of business, real estate, regulatory and transactional matters. He specializes in corporate law, health care law, commercial real estate and real estate finance. ■

## **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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