



New Jersey Health Law

Bulletin

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

Implementation of the New Jersey Medicaid Electronic Health Record Program

Enacted in 2009, the American Recovery and Reinvestment Act ("ARRA") provided States with funding to incentivize hospitals and eligible professionals (the "Providers") to implement and use certified Electronic Health Record ("EHR") technology. EHR technology includes certified technology that aids the Providers in streamlining the use of EHR in a manner compliant with HIPAA standards and allows for the collection of quality clinical data. It is anticipated that EHR technology will serve to reduce medical errors, improve health care outcomes, ensure quality care and reduce health care costs.

On November 7, 2011, New Jersey Medicaid launched its EHR Incentive Program (the "Program") pursuant to the funding provided in ARRA. The Program is designed to provide incentive payments to Providers for the use of EHR technology. In the first year, Providers that show that they have adopted, implemented, or upgraded EHR technology may receive payment from New Jersey Medicaid. To receive payments in subsequent years, however, Providers must demonstrate that the EHR technology is "meaningfully used." Meaningful use is determined based upon whether the Provider has satisfied certain benchmarks

issued by the Centers for Medicare and Medicaid Services ("CMS"). For example, a Provider will be deemed to have meaningfully used EHR technology if the Provider has generated and transmitted prescriptions electronically, provided patients with electronic copies of their health information, or charted changes in a patient's demographic information electronically. Each year, a Provider must attest to Medicaid that it has satisfied all requirements for a Program incentive payment. Upon such demonstration, Medicaid will distribute annual incentive payments to Providers for the use of such technology.

Providers may register for the Program through the State of New Jersey website before March 23, 2012. Through December 27, 2011, currently registered Providers had been permitted to attest to EHR use and qualify for FY2011 first-year payments. ■

Accreditation Required for Advanced Diagnostic Imaging Suppliers

Pursuant to a recent promulgation by the Centers for Medicare and Medicaid Services ("CMS"), physicians, non-physician practitioners, and Independent Diagnostic Testing Facilities ("IDTF") that perform certain advanced diagnostic imaging services (the "Suppliers"), such as magnetic resonance imaging ("MRI"), computed tomography ("CT"), and nuclear medicine imaging (including positron emission tomography) (collectively, the "ADI") must have been accredited by January 1, 2012 in order to submit claims to Medicare for the technical component of such ADI. This requirement does not apply to physicians or facilities that provide x-ray, fluoroscopy, ultrasound, or diagnostic mammography in connection with the Mammography Quality Standards Act. In addition, hospitals, as well as physi-

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Hospital Political Activity May Not Affect Tax-Exempt Status

The Internal Revenue Service ("IRS") recently issued a private letter ruling (the "Ruling") which suggests that hospitals may engage in more substantial political

activities in limited circumstances. The Ruling stated that the requesting hospital could form a separate organization in order to take a more active role in politics.

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Revalidation of CMS Medicare Enrollment Form 855A

In November 2010, the Centers for Medicare and Medicaid Services ("CMS") issued a notice that all providers and suppliers who are enrolled before March 25, 2011 must revalidate their enrollment information every five (5) years in order to maintain Medicare billing privileges. Currently, providers are receiving notices from CMS to update

and revalidate their CMS Enrollment Form 855A. Once a provider receives such notice, the provider has sixty (60) days in which to comply. In addition to revalidation of previously submitted information, the Form 855A contains new data elements in Sections 5 and 6 regarding Ownership Interest and Managing Control Information, as of July 2011. ■

Hospital Political Activity May Not Affect Tax-Exempt Status

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Under the Internal Revenue Code of 1986 ("I.R.C."), organizations which qualify as tax exempt, such as the requesting hospital (the "Hospital"), are prohibited from participating in, or intervening in, any political campaign on behalf of any candidate for public office. Such activity would ordinarily result in penalties or a loss of tax exemption.

In order to engage in lobbying activities, the Hospital sought to form a social welfare organization (the "Organization"). A social welfare organization may directly or indirectly participate in political campaigns without losing its tax exempt status, provided that such political activities do not constitute the "primary" activities of the Organization. Under the proposed arrangement, the Hospital would form the Organization and would be the Organization's sole voting member, with the power to elect the board of directors and approve the budget of the Organization. The board of directors of the Organization would have general control over the affairs and funds of the Organization, and would consist primarily of members of the Hospital's board of directors.

The Organization would, in turn, establish two political action committees (the "PACs"). The purpose of the PACs would be to influence the selection of

individuals to public office and contribute to political campaigns. The majority of the directors on the board of the PACs would consist of members of the Organization's board of directors. However, the boards of the PACs would have exclusive control over the affairs and funds of the PACs and would determine the policies for collection and payment of funds to the candidates and campaigns that the PACs support.

The IRS ruled that the Hospital would not jeopardize its tax exempt status by contributing to political campaigns and engaging in such political activity, provided that the Organization and the PACs operate independently, as set forth in the proposed arrangement. Accordingly, no assets or funds of the Hospital or Organization may be used to establish, administer, or contribute to the PACs. In addition, the Organization must not have any role in soliciting contributions to the PACs or directing funds to certain political candidates or campaigns.

While not binding on other hospitals and taxpayers, the Ruling suggests that hospitals may have the capacity take a more active role in political campaigns. However, before any action is taken in this regard, taxpayers should consult legal counsel. ■

Accreditation Required for Advanced Diagnostic Imaging Suppliers

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cians who interpret the diagnostic images but do not perform the technical component, are exempt from this requirement. An IDTF that uses an accredited mobile facility and bills for the technical component of the ADI services set forth above must also be accredited. All facilities must be accredited for each modality that they supply.

After January 1, 2012, Suppliers of the technical component of ADI that seek to enroll in Medicare for the first time must be accredited by one of three organizations approved by CMS at the time of application in order to be accepted into the Medicare program. The three CMS-approved accrediting organizations are the Joint Commission, the American College of Radiology, and the Intersocietal Accreditation Commission (the "CMS Accrediting Organizations"). Suppliers who are currently enrolled in Medicare and accredited by one of the CMS Accrediting Organizations are not required to take any action. Rather, the CMS Accrediting Organization will alert Medicare directly.

Those Suppliers that seek to become accredited should contact one of the CMS Accrediting Organizations directly, as each organization has varying quality standards. Accordingly, it is advisable that Suppliers review the accreditation standards for each CMS Accrediting Organization in order to determine the accreditation process that best fits the Supplier's business needs. The accreditation process may take up to five (5) months and may involve unannounced site visits by representatives from the CMS Accrediting Organization. ■

LEGISLATIVE & REGULATORY UPDATE

Restrictions on Purchase of Individual Health Benefit Plans

The New Jersey Individual Health Care Board (the "Board") has adopted new rules that discourage adverse selection of health insurance policies. Adverse selection occurs when an individual with significant potential for filing claims seeks to obtain greater insurance coverage. This practice, in turn, can have the effect of raising health insurance costs and premiums for the public. The new rules impose restrictions on the timing of enrollment in new plans. Specifically, individuals are prohibited from purchasing a new health benefits plan for a one month period after abandoning an existing individual health benefits plan. The rules are intended to minimize the risk that an individual will abandon an existing plan with limited coverage and replace it with a plan with greater coverage within a short period of time.

Enrollment as Medical Supply Provider in New Jersey Medicaid/FamilyCare

On November 7, 2011, the New Jersey Department of Human Services ("DHS") adopted new rules regarding an exception to the moratorium on enrollment of new medical supply providers for N.J. Medicaid and N.J. FamilyCare. The amendments allow DHS to enroll new providers of medical supplies for which there is a special need as determined by DHS. Participation by such manufacturers is limited to the specific items required by DHS in special circumstances where the needs of patients are not being met by existing providers.

Use of Advanced Physical Agent Modalities by Occupational Therapy Assistants

On November 7, 2011, the New Jersey Division of Consumer Affairs adopted a new rule expanding the scope of practice for licensed occupational therapy assistants ("OTAs"). Under the supervision of a licensed occupational therapist, OTAs may now utilize advanced physical agent modalities. Both the supervisory occupational therapist and the OTA must complete a training course in advanced physical agent modalities approved by the Occupational Therapy Advisory Council before use of such modalities. The rule also sets forth standards for the supervision of OTAs during the training process.

Health Benefits Plans – Claim Disputes and Standard Forms

The New Jersey Department of Banking and Insurance ("DOBI") has adopted new amendments regarding appeals systems and universal claims forms for health benefits plans. Starting October 17, 2011, all carriers must establish an internal appeals mechanism for disputes between carriers and providers relating to certain payments of claims. Additionally, DOBI, in conjunction with the New Jersey Department of Health and Senior Services, adopted two forms as the universal paper standard for claims by medical institutions, facilities, and providers. The CMS-1450 form (for use by institutions and facilities) and the CMS-1500 form (for use by providers) are available on the Centers for Medicare and Medicaid Services website.

Extension of Moratorium on Adult Day Health Services Facility Applications

Effective immediately, the Department of Health and Senior Services (the "Department") is extending the current moratorium on applications for new adult day health services ("ADHS") facilities until May 1, 2012. The moratorium also applies to the expansion of existing ADHS facilities, authorization to relocate unlicensed facilities, and authorization to operate more than one shift at existing or new facilities. Existing licensed ADHS facilities may commence or continue construction or operation of a replacement ADHS facility that has the same or lower census as the existing facility with the condition that the replacement facility may only be licensed upon the cessation of operation of the existing facility. Additionally, the moratorium on applications for pediatric medical day care facilities remains unchanged.

Patients' Rights in Ambulatory Surgical Centers

The Federal Centers for Medicare and Medicaid Services ("CMS") has amended the patients' rights provisions of the Conditions for Coverage ("CfC") for ambulatory surgical centers ("ASCs"), effective December 23, 2011. The new amendments provide that an ASC must notify the patient, the patient's representative, or the patient's surrogate in writing of a grievance decision. Previously, the provisions required that the ASC only notify the patient. Additionally, in order to accommodate ASCs that perform procedures on the same day that they receive physician referrals, the patient must be provided such notice prior to the start of the surgical procedure. Previously, ASCs were required to provide notice to patients at least one day in advance of the procedure. ■

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Office of Inspector General Advisory Opinions:

Online Referral Service Arrangement May Violate Anti-Kickback Statute

The Office of the Inspector General ("OIG") recently issued an opinion advising a web-based service provider (the "Requestor") on the Anti-Kickback Statute ("AKS") implications of a proposed arrangement (the "Proposed Arrangement") that would facilitate the exchange of information between health care practitioners, providers, and suppliers. The Proposed Arrangement concerns an online health care referral service (the "Referral Service") operated by the Requestor that could potentially induce referrals of Federal health care program business. The Referral Service is an online system through which health care providers can refer patients to other

health care professionals (the "Professionals") electronically. The OIG advised that although the Proposed Arrangement may induce prohibited referrals, the Requestor would not be subject to sanctions.

Under the Proposed Arrangement, the Requestor would operate the Referral Service, through which participating Professionals can receive electronic referrals and exchange patient information. The Professionals may choose to be included on the Referral Service's list of providers free of charge. However, the Requestor would charge a small fee to Professionals for receiving electronic referrals through the Referral Service. This fee is different de-

pending on whether a Professional enters into an agreement with the Requestor to buy other services that the Requestor provides (a "Partner"), or does not enter into an agreement with the Requestor (a "Non-Partner"). Partners are charged for use of the Referral Service at a lower rate than Non-Partners. The structure of the fee schedule could potentially induce health professionals using the Referral Service to refer patients to Partners over Non-Partners.

The OIG concluded, however, that while the Proposed Arrangement may implicate the AKS, it implements sufficient safeguards such that OIG would not subject the Requestor to sanctions. Specifically, because the Requestor provides placement on the list of providers free of charge to any Professional, the Requestor would not control or influence the decision as to which Professional a referral would be made. Additionally, all fees would reflect the fair market value of the actual services provided by the Requestor. Based on the facts and reasoning above, the OIG determined that administrative sanctions would not be imposed on the Proposed Arrangement. ■

About Garfunkel Wild, P.C.

Garfunkel Wild, P.C. (GW) is among the most active health care specialty law firms in the country, with offices in New Jersey, New York and Connecticut. 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. GW also assists numerous health care providers and others to comply with complicated, costly, and often onerous state and federal regulations.

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