

BB REVIEW

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CMS Proposes Draconian 21.5% Cuts to Physician Reimbursement in 2010 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (“CMS”) recently published a proposed rule in the Office of Federal Register updating the 2010 Medicare Physician Fee Schedule (“MPFS”). The proposed rule was published in the Federal Register on July 13, 2009, and may be accessed by visiting <http://www.balch.com/files/upload/FederalRegisterJuly132009.pdf>.

In the proposed rule, CMS announced anticipated changes to the policies and payment rates for services to be furnished in 2010 by physicians and non-physician practitioners who are paid under the MPFS. Specifically, because of the Sustainable Growth Rate (“SGR”) requirement and the accumulation of prior-year negative updates, the 2010 proposed MPFS projects a rate reduction of 21.5%, unless such a result is again averted through Congressional action.

Medicare law, due to the Balanced Budget Act of 1997, requires CMS to adjust MPFS payment rates annually based on a formula incorporating SGR. This formula has yielded negative updates every year beginning in CY 2002, although CMS was able to take administrative steps to avert a reduction in CY 2003, and Congress has taken a series of legislative actions to prevent reductions in CYs 2004-2009. Congress must take action before January 1, 2010, to avert the current projected reduction.

Proposed Reimbursement Changes for Specific Services

Other topics addressed by the proposed rule included: (i) proposing the removal of physician-administered drugs from the definition of “physician services,” thereby eliminating reimbursement for such drugs under the MPFS; (ii) elimination of reimbursement for consultation codes typically used by specialists and paid at a higher rate, with direction that standard evaluation and management codes

should instead be used; and (iii) proposing increasing payment rates for the Initial Preventive Physical Exam (the “IPPE”) to be more in line with payment rates for higher complexity services.

The IPPE benefit, also called the “Welcome to Medicare” visit, was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to pay for an initial assessment of key elements of a beneficiary’s health status within six months of the beneficiary’s enrollment in Medicare Part B. Subsequently, Congress extended the time period for the IPPE benefit to within one year of the beneficiary’s enrollment in Part B.

CMS Gives More Color to Stand In Shoes Rule

Finally, CMS further discussed the Stark “stand in shoes” concept in the proposed rule. Specifically, CMS proposes to clarify that not all physicians in a physician organization are required to sign the writing(s) memorializing a compensation arrangement between the physician organization to which the physician belongs and the entity furnishing designated health services. Further, CMS proposes to clarify that the relevant referrals and business generated between the physician organization and the entity furnishing designated health services are the referrals of all physicians in the organization, not simply referrals made by each physician who stands in shoes of the physician organization.

Proposal to Revise Supervision Requirements for Outpatient Therapeutic Services

On July 1, 2009, The Centers for Medicare & Medicaid Services (“CMS”) released the outpatient prospective payment system (“OPPS”) proposed rule for calendar year 2010 (the “Proposed Rule”). CMS is proposing to revise the physician supervision requirements applicable to hospital outpatient therapeutic services described in the 2009 OPPS final rule in response to concerns raised by the American

**BALCH & BINGHAM LLP
HEALTHCARE CONTACTS**

IN ATLANTA

30 Ivan Allen, Jr. Blvd., NW,
Suite 700
Atlanta, GA 30308

Richard D. Sanders

(404) 962-3578

rsanders@balch.com

Philip M. Sprinkle, II

(404) 962-3573

psprinkle@balch.com

**HEALTH LAW PRACTICE
GROUP MEMBERS IN**

ATLANTA

Chris Anulewicz

Mike Bowers

Natalie Christensen

Dart Meadows

Jennifer Richter

Michelle Rothenberg-Williams

Rich Sanders

Philip Sprinkle

Address Change . . .

If you no longer wish to receive this update or have an address change, please contact:

Nora Yardley

205-226-3476

nyardley@balch.com

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Hospital Association and other hospital and physician groups.

In the Proposed Rule, CMS proposes the following changes to the outpatient therapeutic services supervision requirements which, if finalized, would become effective on January 1, 2010:

1. CMS proposes to expand the physician supervision requirements to allow “non-physician practitioners” to directly supervise hospital outpatient therapeutic services (other than cardiac rehabilitation, intensive cardiac rehabilitation and pulmonary rehabilitation). Such “non-physician practitioners” include physician assistants, nurse practitioners, certified nurse mid-wives and clinical nurse specialists. Under the Proposed Rule, the non-physician practitioners will be permitted to supervise only those services that they are able to personally perform within their State’s scope of practice and hospital-granted privileges.

2. For outpatient therapeutic services provided in the hospital or in an on-campus provider-based department of the hospital, CMS will no longer require the supervising physician to be physically present in the department when services are furnished. Instead, CMS proposes to loosen the definition of “direct supervision” to mean that the physician or non-physician practitioner must be present “on the same campus,” meaning “in the hospital or in an on-campus provider-based department of the hospital” and immediately available to furnish assistance and direction throughout the performance of the procedure.

3. For services furnished in an off-campus provider-based department, “direct supervision” would continue to mean that the physician or non-physician practitioner must be present in the off-campus provider-based department at all times services are furnished. This definition of “direct supervision” is virtually identical to that required of incident to services provided in a physician’s office.

With regard to other issues involving off-campus provider-based departments, CMS stated that it would be inappropriate for one physician or non-physician practitioner to supervise all services provided in such departments. CMS considers it highly unlikely that one physician or non-physician practitioner would be immediately available at all times that outpatient therapeutic services are being provided and would have the knowledge and ability to adequately supervise all services being performed at once in multiple off-campus provider-based departments. This places a burden on hospitals to examine the services and procedures provided in off-campus provider-

based departments and ensure that the supervising physicians and non-physician practitioners have the requisite skills to supervise all of the services and procedures being provided.

4. CMS has additionally clarified in terms of supervision provided on-campus that even though hospital medical staff supervising the services “need not be in the same department as the ordering physician,” the supervisory physician or non-physician practitioner must have, within his or her scope of practice and hospital-granted privileges, the ability to perform the service or procedure that he or she is supervising.

OIG Approves Hospital Gainsharing Agreement

The Department of Health and Human Services Office of Inspector General (“OIG”) recently approved a hospital gainsharing agreement, stating that a hospital and certain physician groups may share a percentage of hospital cost-savings arising out of physicians’ implementation of cost-reduction measures in certain cardiac catheterization procedures. OIG Advisory Opinion No. 09-06 was posted June 30, 2009, and involved a proposed arrangement through which an acute care hospital would pay a cardiology group, a vascular surgical group, and an interventional radiology group a share of the cost-savings directly attributable to specific changes made by each group.

Although the OIG noted that hospital cost-savings programs could constitute an improper payment subject to a civil monetary penalty, it found that the proposed arrangement contained sufficient safeguards and declined to seek sanctions by way of civil monetary penalty. Because the cost-saving actions and resulting savings were clearly and separately identified, the OIG was satisfied with the amount of transparency allowing for public scrutiny and individual physician accountability. The OIG also highlighted factors of the agreement that protected against inappropriate reductions in patient services, including the limited amount and duration of financial incentives.

The OIG further noted that, while the arrangement did not fit into the Anti-Kickback safe harbor for personal services and management contracts since the aggregate compensation was not set in advance, it would not impose sanctions.

The OIG noted several factors in its decision to allow the gainsharing agreement, including that the arrangement was limited to physicians already on the medical staff, potential savings derived from procedures for federal healthcare

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BALCH & BINGHAM LLP

**BALCH & BINGHAM LLP
HEALTHCARE CONTACTS
IN BIRMINGHAM**

1901 Sixth Avenue North, Suite
1500
Birmingham, AL 35203

Matthew A. Aiken
(205) 226-3425
maiken@balch.com

Cavender C. "Chris" Kimble
(205) 226-3437
ckimble@balch.com

Jack Levy
(205) 226-8750
jlevy@balch.com

**HEALTH LAW PRACTICE
GROUP MEMBERS IN
BIRMINGHAM**

Matt Aiken
Bert Amason
Bruce Barze
Hamp Boles
Andy Buck
Mike Edwards
Robin Franco
Ed Haden
Judd Harwood
Leigh Anne Hodge
Chris Kimble
Jimmy King
Kristen Larremore
Alex Leath
David Lester
Jack Levy
Colin Luke
John Markus
Carey McRae
Teresa Minor
Dan Murphy
Phil Nichols
Katy Ottensmeyer
Steve Parham
Kimberly Powell
Laura Schiele Robinson
Monica Sargent
Bill Shanks
Pam Payne Smith
Chris Terrell
Craig Williams
Lois Woodward
Chris Yeilding

program beneficiaries were capped, and the period for which payments were to be calculated was limited to one year.

OIG Advisory Opinion No. 09-06 may be accessed by visiting the following website: <http://www.balch.com/files/upload/AdvOpn0906.pdf>.

**Supreme Court of Georgia Narrows
Scope of Peer Review Privilege**

Through its June 8, 2009, holding in *Hospital Authority of Valdosta and Lowndes County v. Meeks*, the Supreme Court of Georgia narrowed the statutory peer review privilege, which prevents certain medical peer review materials from being discovered. *Hosp. Auth. of Valdosta & Lowndes County v. Meeks*, No. S09G0466 (Ga., Jun. 8, 2009).

Following the death of his wife, Thurman Meeks brought suit against the Hospital Authority of Valdosta and Lowndes County, d/b/a South Georgia Medical Center ("Hospital") for negligent credentialing and against a Hospital physician for the cardiac procedure that resulted in the death of his wife. In response to a discovery request for the physician's credentialing files, the Hospital filed a motion for protective order, asserting the files were privileged under Georgia's peer review statutes. The trial court ruled that the credentialing files were protected, but limited its holding to the contents of review and credentialing files. The Court of Appeals reversed, holding that all proceedings and information of a review organization are privileged, not just documents included in physical files.

On certiorari review, the Supreme Court of Georgia held that statutory privileges for medical review committee and medical peer review proceedings and records do not extend to physician credentialing information, unless the information involves the evaluation of the quality and efficiency of actual medical services.

**Congressman Davis Briefs Alabamians on
Details of Healthcare Reform; Seeks Counsel**

On July 6, 2009, U.S. Representative Artur Davis (D-AL) hosted a Healthcare Summit at UAB's Alys Stephens Center for Performing Arts in Birmingham, Alabama.

During the event, Rep. Davis asked an impressive panel consisting of small business owners, various hospital and health care provider administrators, insurance company executives and non-profit executives for their input on how the federal government should

pursue healthcare reform. While panelists unanimously agreed that reform is needed, there was little agreement on how to best achieve that goal. The subject of how to pay for reform was hardly broached.

Rep. Davis supports the Tri-Committee Health Care Reform Plan (the "Plan"), being prepared by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor. He says the Plan will receive mark up this week. He then hopes Congress will vote on the Plan by the August recess with the ultimate goal of putting it before President Obama to sign it into law by the end of the year.

The Plan would create a new Health Insurance Exchange for individuals and small employers to comparison shop for health coverage, and would provide reforms and consumer protections to the health insurance industry, grant individual affordability credits for the purchase of health insurance on a sliding scale to Americans with incomes up to 400% of the Federal Poverty Line. The Plan also contains a "public option" government health insurance plan available to all Americans and includes "pay or play" mandates to many businesses to provide health insurance to employees or face an 8% payroll tax.

Many panelists expressed concerns that public options might push private insurers out of the market and eventually limit options for beneficiaries or harm the quality of health insurance in the U.S. Panelists also noted that the aggressive timetable for passing the Plan, which currently lacks many details about how it will be implemented, might lead to unintended negative consequences. Alabama Department of Public Health State Health Officer Donald Williamson, MD, a panelist, stated that the "devil will be in the details" in terms of how a public option might cover things such as preventive health services. Hopefully, caregivers will be rewarded for primary prevention, such as lowering hypertension in patients, Dr. Williamson added.

About 500 members of the public attended the event.

**Alabama Legislature Changes Hospice
Law**

In May, the Alabama Legislature passed a law finalizing several years of stagnation in the hospice industry. Under Act 2009-492, hospice is now a new institutional health service subject to Certificate of Need rules. Further, the moratorium on the licensure of new hospices has been lifted.

**BALCH & BINGHAM LLP
HEALTHCARE CONTACT
IN GULFPORT**

1310 Twenty Fifth Ave
Gulfport, MS 39501-1931

H. Rodger Wilder
(228) 214-0412
rwilder@balch.com

**HEALTH LAW PRACTICE
GROUP MEMBERS IN
GULFPORT**

Ann Bailey
Paul Delcambre
Rodger Wilder

**BALCH & BINGHAM LLP
HEALTHCARE CONTACT
IN JACKSON**

401 East Capitol Street, Suite
200
Jackson, MS 39201-2608

Dinetia Newman
(601) 965-8169
dnewman@balch.com

**HEALTH LAW PRACTICE
GROUP MEMBERS IN
JACKSON**

Armin Moeller
Dinetia Newman

**BALCH & BINGHAM LLP
HEALTHCARE CONTACT
IN MONTGOMERY**

105 Tallapoosa Street, Suite
200
Montgomery, AL 36104

J. Dorman Walker
(334) 269-3138
dwalker@balch.com

**HEALTH LAW PRACTICE
GROUP MEMBERS IN
MONTGOMERY**

JoClaudia Moore
Will Sellers
Dorman Walker

Full text of Act 2009-492 may be accessed by visiting:

<http://www.balch.com/files/upload/AlabamaAct2009492.pdf>

**Mississippi Legislature Extends Funding
for Division of Medicaid**

During its recent Second Extraordinary Session and after heated debate in the House and Senate, the Mississippi Legislature enacted House Bill 71, which addresses hospitals' roles in financing the state Medicaid program and extends the state Division of Medicaid until 2012.

Effective July 1, 2009, the existing hospital "bed tax" was repealed, and new annual assessments are to be levied on hospitals on a sliding scale basis during fiscal years 2010, 2011, and 2012. The assessment applies to each non-Medicare hospital inpatient day. Although a complex formula is used to determine the sliding scale assessments, Mississippi hospitals will be taxed \$60 million and up to \$6 million of any deficit in 2010; \$63.75 million and up to \$8 million of any deficit in 2011; and \$90 million and up to \$10 million of any deficit in 2012.

Additionally, the bill requires that hospitals receive the Medicare published market basket inflationary index payment increase and allows all hospitals meeting minimum federal eligibility requirements to participate in the disproportionate share hospital program.

Finally, effective January 1, 2010, all fees for physician fees covered only by Medicare shall be increased to 90% of the established rate, while the previous 5% cut in physician reimbursements from the Musgrove Administration will be restored.

Full text of House Bill 71 may be accessed by visiting

<http://www.balch.com/files/upload/HB0071SG.pdf>.