

BB REVIEW

Healthcare News
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HEALTH INFORMATION TECHNOLOGY

CMS, OIG Release Final Health IT Rules

On August 1, the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) released final rules to speed the adoption of electronic prescribing and electronic health records.

The OIG rule establishes two new safe harbors under the Anti-Kickback Statute. First, hospitals and certain other entities may provide physicians with hardware, software, or information technology and training services necessary and used solely for electronic prescribing. Second, entities furnishing designated health services may donate to physicians' interoperable electronic health records software, information technology, and training services.

The CMS rule creates two new exceptions under the physician self-referral (Stark) law covering arrangements involving the donation of electronic health records technology and protecting the provision of software or information technology and training services that are necessary and used predominantly to create, maintain, transmit, or receive the electronic health records of the donor's or physician's patients.

CCHIT Certifies Ambulatory EHRs

The Certification Commission for Healthcare Information Technology (CCHIT) announced the certification of the first round of ambulatory electronic health record products (EHRs) on July 18. The Department of Health and Human Services (DHHS) awarded a \$2.7 million contract in September 2005 to CCHIT, a private, non-profit organization, to develop an efficient, credible, and sustainable mechanism for certifying health care information technology

products. CCHIT will certify health information technology (HIT) products in three phases: outpatient/ambulatory EHRs, inpatient/hospital EHRs, and architectures or systems that enable the exchange of information between and among health care providers and institutions.

CCHIT certification indicates that EHR products meet base-line levels of functionality, interoperability and security in compliance with CCHIT's published criteria. This limits the risk associated with investing in HIT and "gives health care providers peace of mind to know they are purchasing a product that is functional, and interoperable and will bring higher quality, safer care to patients."

For a list of certified EHRs, visit www.cchit.org.

TAX ISSUES

Mississippi-Based Home Health Agency Wins Tax Appeal

On July 11, the U.S. Court of Appeals for the Fifth Circuit reversed a ruling of the U.S. Tax Court and removed a \$69.7 million tax bill imposed on the managers of a Mississippi-based home health care agency. In 1995, Caracci family-owned home health care agency, the Sta-Home, converted from tax-exempt to nonexempt status. This conversion resulted in deficiency notices to the Caracci family from the Internal Revenue Service (IRS) and a resulting dispute centered on whether any gain had been recognized in the conversion.

The IRS had argued that the Caraccis had violated I.R.C. Section 4958, which is meant to prevent acts of self-dealing between private foundations and company insiders. The code imposes a 25 percent tax on those persons who benefit from conversion such as that of Sta-Home. However, the appeals court found that the IRS could not meet its burden of proof and held that there had been no gain in the conversion.

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In its decision, the appeals court was critical of both the IRS and the Tax Court writing, "Stahome took a careful and conscientious approach to the conversion." Further, "There are so many legal and factual errors – many of which the [IRS] Commission acknowledges – infecting this case from the outset that reversal must result." Additionally, the Tax Court did not properly take into account what it knew to be the inadequacy of the IRS analysis.

The 42-page ruling can be viewed at: <http://www.balch.com/HealthCare/CaracciCase.pdf>

Mississippi to Tax Hospitals to Close Medicaid Budget Gap

Mississippi Governor Haley Barbour (R) announced in an August 8 statement that the Mississippi Medicaid program has submitted to the Centers for Medicare & Medicaid Services an alternative hospital payments program that would require public hospitals to send twenty-four percent of all Medicaid payments received back to the state Medicaid agency. This program modifies current practice, which requires hospitals return only part of one type of Medicaid payment to the state Medicaid agency. This new program is set to be effective September 1, 2006, pending approval of the Centers for Medicare & Medicaid Services.

The Mississippi Hospital Association, to which most of the state's hospitals belong, is not endorsing the alternative program, even though the alternative program was developed by Association staff. Barbour believes that the program will cover all funds previously paid in connection with the non-federal share of Medicaid upper payment limit distributions. Supporters also contend that the program will prevent Mississippi hospitals from losing \$360 million worth of future net revenue. Those opposing the new program argue that it is simply an effort to "replace lost federal funding," and will not provide a long-term fix for Medicaid problems.

Previously, Mississippi took about \$90 million from public hospitals and matched that with \$270 million from the federal government as part of a 3-to-1 federal match for every dollar spent on Medicaid care. The federal government put a stop to this accounting maneuver in 2005, resulting in a \$360 million gap in funding.

On July 5, Governor Barbour announced that the state had a \$70 million budget surplus, prompting some lawmakers to argue that the money should go towards the Medicaid shortfall. He and other government officials are recommending that legislators act conservatively in spending the surplus as it may

be "one-time money." Barbour acknowledged that while that tax is not the ideal solution, his office will "continue to find ways to make it better for everybody."

PRIVACY

HIPAA Preempts Georgia Tort Reform Law Requiring Release of Medical Records

On July 13, a state appeals court ruled that a Georgia statute requiring medical malpractice plaintiffs to file a medical record release authorization with their complaint is preempted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 9-11-9.2 of the Georgia Code requires a plaintiff to file a medical record release authorization form with a medical malpractice complaint, allowing the defendant to obtain the plaintiff's protected health information ("PHI") to investigate, evaluate, and defend the malpractice claim.

The plaintiff, Linda Queen, originally filed a form with her complaint against Northlake Medical Center LLC authorizing her medical providers to release her medical records only to her attorneys. This authorization did not satisfy Ga. Code § 9-11-9.2. However, the Georgia Court of Appeals affirmed the trial court ruling that Queen is not required to file a release in compliance with the Georgia statute because it is preempted by HIPAA's requirements for a valid authorization to disclose PHI.

As a result of the ruling, plaintiffs will no longer be required to allow defense lawyers and insurance companies to access their PHI secretly and without any duty to notify the patient. Defendants will still be able to obtain relevant health information by serving the plaintiff with production requests, subpoenas, or taking depositions. The ruling will also prevent improper ex parte communications between defense counsel and a plaintiff's physicians.

Mississippi Supreme Court Reinstates Some Claims of Patient Against Blue Cross

A covered dependent of a health plan subscriber may pursue breach of confidentiality and negligent infliction of emotional distress claims against the plan, under the terms of a Mississippi Supreme Court decision issued Aug. 10 (Robley v. Blue Cross/Blue Shield of Mississippi, Miss., No. 2003-CT- 02209-SCT,8/10/06).

The state high court reinstated claims brought by Cheryl Robley, who alleged that a Blue Cross/Blue Shield of Mississippi case manager



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referred to her as a "drug seeker" -- or individual who abuses prescription drug -- in a conversation with a prospective provider of wound care services.

Robley could not prove that the contract between her husband and BC/BS Mississippi gave rise to a fiduciary obligation by the plan, and those claims therefore had to be dismissed, the court said. However, she did establish that BC/BS may have breached her right to confidentiality by disclosing the derogatory assessment, the court added.

The court also found that she had demonstrated sufficient evidence of injury from the disclosure to support her claim for damages. The court further found that the determination of liability and damages should, on remand, be determined by a jury.

Disclosure

Although the language of the policy seems to give broad authority, Blue Cross does not have unfettered discretion to disseminate Robley's medical records, the court said. "There still remains a dispute between [a wound care center employee and a Blue Cross employee] as to whether the term 'drug seeker' was used. There was evidence presented at trial by both which contradicts the other's story. This conflict should have been decided by the jury rather than the judge," the court concluded.

The court's decision is available at <http://www.mssc.state.ms.us/Images/Opinions/C035885.pdf>

FRAUD & ABUSE

The Deficit Reduction Act of 2005: New Requirements Aimed at Educating Employees about False Claims Recovery

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (the "DRA") into law. Among a large scheme of changes, the DRA contains new requirements geared toward detecting and preventing Medicaid fraud. This summary provides an overview of the new law, its requirements, and tips for medical providers to remain compliant.

Entities affected

Under the DRA, any entity which receives or makes annual payments of at least \$5,000,000 must comply with the new requirements to continue receiving federal funding. The requirements extend both to the covered entities and to its vendors.

New requirements

Section 6302 of the DRA requires that by January 1, 2007 entities establish written

policies discussing fraud prevention laws and include the information in employee handbooks. More specifically, entities must establish policies that provide detailed information about: 1) the False Claims Act; 2) its administrative remedies; 3) any state laws discussing false claims; 4) whistleblower protection under such laws; and 5) the role these laws play in preventing and detecting Medicaid fraud, waste and abuse. Within these new policies, entities must include, in detail, their own policies and procedures for detecting and preventing fraud.

Section 6302 also requires that all employee handbooks, including management, address fraud detection laws, highlight the rights of employees to have protection under whistleblower laws, and describe the entity's policies and procedures for preventing fraud.

Congress has not specified the level of "detailed information" required for compliance. However, the DRA's purpose is to educate employees and facilitate the prevention of Medicaid fraud, waste and abuse. Entities should bear this goal in mind when selecting the amount of information to include in their policies and employee handbooks.

Tips for compliance

The DRA's requirements apply to both employees and a medical provider's vendors. Therefore, a medical provider must distribute copies of its new policies to all vendors and ensure that they also comply with the DRA. A medical provider may want to protect itself from vendor non-compliance by incorporating the DRA's terms into the "Terms and Agreements" portion of its purchase order forms.

Non-compliance

Non-compliant entities stand to lose their federal funding. Accordingly, entities should ensure that they, and their vendors, have attempted to comply fully with the DRA.

Summary

The DRA requires that by 2007 entities receiving federal funding over \$5,000,000 dollars update their employee handbooks and create policies which educate employees about the False Claims Act.

Piedmont Hospital Settles Health Care Fraud Allegations

In the midst of its dispute with Blue Cross/Blue Shield of Georgia, The United States Attorney's Office for the Northern District of Georgia announced on June 9, 2006 that Piedmont Hospital (Atlanta) has agreed to pay over \$3 million in exchange for dismissal of a qui tam (i.e., whistleblower) lawsuit filed in July 2003. In the lawsuit, filed by Patricia J. Quinnelly, a



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vascular technologist at the facility from 2001 to 2004, it was alleged that Piedmont Hospital violated the False Claims Act by submitting claims to federal health care programs for services that were not eligible for reimbursement. Specifically, Quinnelly alleged that Piedmont Hospital submitted claims for a physician's interpretation of some vascular laboratory tests that were actually the technicians' interpretations and proposed diagnoses rather than the results of an independent review by laboratory physicians as required by law.

The investigation of these charges led to the discovery that Piedmont Hospital had also failed to execute contractual agreements with the physicians performing services at the vascular laboratory, as required by Stark Law, 42 U.S.C. § 1395nm, designed to regulate physicians' referrals to entities in which they have a financial interest.

Under the False Claims Act, 29 U.S.C. § 3729 et seq., the United States is able to recover triple damages and civil penalties for false claims knowingly submitted to government programs. In addition to payment of the \$3,039,388, Piedmont Hospital was also required to enter into a Certification of Compliance Agreement with the Office of Inspector General. Under this agreement, Piedmont Hospital is required to adhere to certain policies and procedures to ensure compliance with applicable statutes and regulations that govern the use of federal health care funds. Quinnelly will receive \$354,390 under qui tam provision of the False Claims Act as her share of the recovery under the settlement.

Lincare Settlement Leads OIG to Physicians

On May 15, Lincare Holdings, a medical equipment supplier with locations in 47 states, announced that it had entered a civil settlement calling for a \$10 million payment to OIG and a five-year corporate integrity agreement to resolve allegations that it bribed physicians for referrals. From 1993 through 2000, Lincare gave physicians across the country sporting and entertainment tickets, gift certificates, rounds of golf, fishing trips, meals and other gifts in return for referring patients for its oxygen and respiratory services. These illegal kickbacks were disguised as payments for purported consulting, medical directors, advisors and respiratory service and therapy agreements.

Physicians should be concerned because Lincare will be helping OIG with related investigations in order to file charges against those who accepted gifts or payments in exchange for referrals from Lincare between 1993 and 2000.

As with all high dollar settlements, physicians and healthcare organizations should use this as an early warning system and check their dealings with providers for the taint of fraud to ensure that they are not accused of being guilty by association. OIG has already convinced two Florida pulmonologists to pay more than five times the value of sporting event tickets and expensive meals they received from Lincare, in a settlement of \$122,000.

HOSPITAL INTEREST

Federal Court in Georgia Rules on EMTALA Case

On May 23, 2006, the United States District Court for the Middle District of Georgia ruled in favor of John D. Archbold Memorial Hospital (Archbold) in a case asserting EMTALA and state law claims. The plaintiff, Vickie Bryant, sought treatment at Archbold after suffering injuries in a car accident. Bryant received examination by a triage nurse within 15 minutes of her arrival who documented the plaintiff's symptoms (left rib and shoulder pain) and referred her to further examination by an emergency physician.

Bryant was seen by Dr. Michael Crowley within an hour of her arrival in the ER. Dr. Crowley's examination determined that the plaintiff's head, neck and heart were all functioning normally, however a left rib x-ray series revealed two fractured ribs. Bryant was subsequently given a prescription for pain medication and discharged from the ER.

Bryant returned to the hospital a few days later and was diagnosed with a ruptured spleen, requiring emergency surgery. She then sued both Archbold and Crowley, seeking damages for her misdiagnosis, asserting an inadequate-screening claim under EMTALA and a state law claim of negligence.

Archbold and Crowley filed a motion for summary judgment arguing that Bryant failed to establish the inadequate-screening claim because she received an extensive screening consistent with the hospital's standard ER procedures. The court granted the defendants' summary judgment motion, stating that so long as a patient's treatment is consistent with the hospital's standard screening procedures, the hospital meets the adequate screening requirement.

Furthermore, the court stated that Bryant's argument that Crowley never physically touched her abdomen was immaterial to Bryant's EMTALA claim because "EMTALA requires only that hospitals provide a medical screening similar to the one which they would provide any



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other patient” and this does not necessarily include a physical examination of one’s abdomen.

The court concluded by finding the plaintiff’s treatment by both the physician and hospital of the same caliber as treatment provided to other patients and thus “Without some evidence from which the Court could infer that [Bryant] was treated by [Archbold] differently than others, the Court has no choice but to enter summary judgment in favor of Archbold on [the] EMTALA claim.” The court ordered the dismissal without prejudice of an additional claim of negligence under state law by Bryant.

Georgia Court of Appeals Rules in Favor of Hospital on Alleged Overcharges

The appeals court affirmed a lower court’s decision to grant summary judgment in favor of Douglas Hospital in charges filed by Michael and William Morrell, two uninsured patients claiming that the hospital overcharged them. The Morrells argued that the rates charged were “grossly in excess” of rates charged to private medical insurers and Medicare/Medicaid programs for the same medical care.

Their complaint listed numerous counts including that breach of contract had occurred. This claim could not be established because both individuals signed an agreement-to-pay contract that clearly referred to a written summary of specific charges available upon request by the patient. The trial court was deemed to have correctly determined that “the agreement in the contract to pay for ‘all charges’ unambiguously referred to the written summary of specific charges...which established the price terms on which the parties intended to bind themselves.”

The appeals court also rejected the Morrells’ argument that the lower court erred in dismissing its breach of fiduciary duty claim. The appeals court found that a nonprofit hospital, such as Douglas Hospital, has “no fiduciary duty to a patient with respect to the price the hospital charges for medical care” and that the Morrells’ assertion that a fiduciary duty existed to charge patients without insurance for medical care on a non-profit reasonable basis was invalid.

CERTIFICATE OF NEED

Mississippi Supreme Court Upholds Revocation of CON

The Mississippi Supreme Court recently upheld a state chancery court’s revocation of the state Department of Health’s (DOH) issuance of a certificate of need (CON) to St. Dominic-

Jackson Memorial Hospital (St. Dominic), a general acute care hospital located in Jackson. St. Dominic originally filed a CON application in June 2002 requesting approval to build a new 100-bed hospital in Madison County and in September of that same year amended the original application to change it from a new facility request to a relocation request. Under the revised request, St. Dominic sought to relocate 100 of its 571 licensed beds in the Jackson hospital to the proposed new facility in Madison County.

Filings opposing St. Dominic’s amended CON application were submitted by Madison County Medical Center (MCMC), the only existing hospital in Madison County. MCMC argued that Madison County already had excess patient beds thereby mitigating the need for St. Dominic to relocate 100 beds to the county. Furthermore, MCMC argued that the difference between St. Dominic’s original new facility request and amended relocation request was immaterial.

However, the hearing officer viewed St. Dominic’s application simply as a relocation request. Under the applied criteria, it was recommended that DOH grant the hospital a CON for 50 (rather than 100) beds in Madison County. This decision was appealed by MCMC on the basis that the application should have been reviewed as a request for new facility rather than a request for relocation. The chancery court agreed and reversed DOH’s grant of the CON to St. Dominic. Additionally, St. Dominic admitted that it could not meet the need requirement for a new facility CON and so the case was not further pursued.

The Mississippi Supreme Court upheld this ruling, noting that the CON application proposed a new building with new medical staff and equipment, rather than the transfer of such from the Jackson facility. Thus, the high court ruled that granting of the CON should have been based on what the proposed facility “actually is” in relation to the appropriate standard of need.

PHYSICIAN INTERESTS

Alabama Board of Physical Therapy Proposes to Curtail Physician Ownership of Physical Therapy Practices

Many Alabama physicians, particularly orthopedic surgeons, currently employ physical therapists to serve their patients. This practice will become much less commonplace if the Alabama Board of Physical Therapy (the “Board”) gets its way. On June 20, 2006, the Board sent all Alabama licensed physical therapists and physical therapy assistants, a notice of intended regulatory action seeking to amend Rule 700-X-3-02.



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The proposed regulation makes it unlawful for a physical therapist to provide physical therapy or supervise the provision of physical therapy services to a patient that is referred by a physician or dentist that has a "referral conflict of interest" with the therapist unless an exception applies. The proposed regulation essentially re-defines a "referral conflict of interest" and would prohibit a physical therapist from accepting a referral from a physician with whom he or she shares a financial interest on the grounds that it would constitute unprofessional conduct. (A summary of this notice can be found at http://www.pt.alabama.gov/pdfs/NoticeofIntendedAction_6_06.pdf)

There are several important exceptions in the proposed regulations. Significantly, the regulation grandfathers "referral conflicts of interest" that were in place prior to June 1, 2006 so long as the therapist files a certification with the Board within the six month period after the adoption of the proposed rule. It is important to note that this exception is only applicable to the therapists that were previously involved in the financial relationship and that new therapists would not be able to take advantage of this provision.

In addition, the draft rule permits physical therapists to lease space from physicians or physician group practices so long as the rental payments are consistent with fair market value and are not determined by the revenues or profits of the physical therapy practice. Likewise, the proposed regulations permit physician ownership of therapy practices where there is only one physical therapy practice in a micropolitan statistical area or where the physician owns less than 5% of the shares of a publicly-owned corporation that owns the physical therapy practice. There are also exceptions for debt associated with the sale of a physical therapy practice to a therapist by a physician so long as the sale does not include any payments for the referral relationships.

It is helpful to understand the Board's stated objective behind the regulations. In the cover memorandum for the regulation, the Board provides that it is implementing a "best practices" standard that will help "control health care costs" and serve the patients. The Board argues that the greatest threat to the "balance of competing interests" in health care costs involves the inherent conflicts of interest that arise within the context of referrals. The Board cites one study in which 84% of medical residents thought their colleagues were influenced by gifts from drug companies. As a result, the Board argues that therapists may be the recipient of questionable referrals when the physician has a financial relationship with the therapist.

To fully understand the context for the proposed regulations, it is also helpful to be aware of the legislative objectives of many physical therapy associations. In a number of states other than Alabama, physical therapists are able to evaluate and treat patients without a physician referral. Many state associations are promoting the notion that any physician involvement in physical therapy practices is costly and unnecessary. These associations cite a report by the Office of Inspector General of the Department of Health and Human Services ("OIG") that concluded many physician-owned therapy practices frequently did not comply with Medicare billing requirements.

In this report, the OIG concluded that 91% of physical therapy services billed by physicians in the first 6 months of 2002 failed to meet Medicare requirements and that these failures accounted for improper Medicare payments of approximately \$136 million. The OIG found that the total payments for physical therapy claims from physicians increased from \$353 million in 2002 to \$509 million in 2004, and that the number of physicians who billed the program for more than \$1 million in physical therapy annually more than doubled in that 2-year period. Many physicians question the validity and conclusions of this report and argue that physical therapists are really seeking greater financial reimbursement for their services in their efforts to eliminate the requirement for physician referrals.

It should be noted that it is still uncertain at this time if the proposed regulations will be finally implemented in their current form. The Board itself may modify these rules in response to public comments received before August 3, 2006. Moreover, under the Administrative Procedures Act, a joint committee of the Alabama Legislature has the opportunity to reject the proposed regulations. It is likely that physicians, particularly those that employ physical therapists and physician groups will make their voices heard on the proposed regulations.

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