

# BB REVIEW

## Healthcare News November/December 2006

### What's Inside . . .

#### I MEDICARE

- *Medicare Reimbursements Cut Under Final Rule*
- *Gainsharing Demonstration*
- *CMS Implements Pay For Performance For Small Physician Practices*

#### II FRAUD & ABUSE

- *OIG Executes Tenet Corporate Integrity Agreement*
- *Northside Hospital Settles Whistleblower Lawsuit*
- *OIG Issues Six Advisory Opinions in Five Weeks*

#### III TAX ISSUES

- *Mississippi Hospitals Block Medicaid-Related Tax*

#### IV PRIVACY

- *Georgia Disclosure Law Preempted by HIPAA, Appeals Court Rules*

#### V HEALTH INSURANCE

- *Alabama Court Dismisses Two Claims, Reinstates One in Premium Payment Dispute*
- *Georgia Receives Federal Approval To Offer Health Coverage Tax Credit*

#### VI EMTALA

- *CMS Revised Its EMTALA Rules in August 2006*
- *Federal Court Dismisses Claims In Lawsuit Over Alleged Failure to Stabilize*

#### VII CERTIFICATE OF NEED

- *New Certificate of Need Application Fee*
- *Cyber Knife*

#### VIII COMMENTARY

- *The Danger of Avoiding Peer Reviews*

#### MEDICARE

##### Physician Medicare Reimbursements Cut By Five Percent in 2007 Under Final Rule

Medicare payments to physicians will be cut by five percent in 2007 under a final physician fee schedule rule issued Nov. 1 by the Centers for Medicare & Medicaid Services.

The five percent cut is a slight change from the 5.1 percent reduction calculated when the rule was published in proposed form in August. The formula compares the actual growth of physician services in spending to a target rate. If the actual rate exceeds the target, the update is decreased.

##### Gainsharing Demonstration

CMS recently announced demonstration projects under Section 646 of the Medicare Modernization Act ("MMA") that create an opportunity to implement a 3-year demonstration that will test gainsharing models involving physicians and collaborations among hospitals working with physicians in a single geographic area to improve quality and efficiency. Gainsharing will be tested and evaluated as a provider payment model aimed at aligning physician incentives with hospital incentives by allowing physicians to share in the savings generated by adoption of structural and process changes necessary to improve the quality of inpatient hospital care. This demonstration is expected to begin in 2007.

In contrast to traditional models of gainsharing, this approach must be of sufficient size (across single or multiple organizations) and involve long-term follow-up to assure both documented improvements in quality and reductions in the overall costs of care. CMS is particularly interested in demonstration designs that track patients well beyond a hospital episode, to

determine the impact of hospital-physician collaborations on preventing short- and longer-term complications, duplication of services, coordination of care across settings, and other quality improvements that hold great promise for eliminating preventable complications and unnecessary costs.

As stipulated in the MMA, health care groups that are eligible to apply for the demonstration are defined as: (i) physician groups, (ii) Integrated Delivery Systems (IDSs); or (iii) organizations representing coalitions of physician groups or IDSs.

CMS will give preference to projects developed and implemented by a consortium of health care groups and their affiliated hospitals. The deadline for applications is January 9, 2007.

#### FRAUD AND ABUSE

##### OIG Executes Corporate Integrity Agreement with Tenet Healthcare

The CIA is part of Tenet's resolution of its civil and administrative liability for a wide range of investigated conduct, including Diagnosis Related Group (DRG) upcoding, improper outlier payments, kickbacks to physicians, and other alleged fraudulent activities.

In June 2006, Tenet agreed to pay over \$900 million to the United States to resolve its liability under the False Claims Act and related authorities. Specifically, the Federal government had alleged that Tenet submitted claims for payment to Medicare using DRG codes that Tenet could not support or were improperly assigned to patient records in order to increase reimbursement to Tenet hospitals.

The CIA, which has a five-year term, requires the Quality, Compliance, and Ethics Committee of Tenet's Board of Directors to undertake a review of the effectiveness of Tenet's

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compliance program and adopt resolutions with respect to this review. Tenet is required to submit annual reports to OIG, which will include certifications by Tenet officers that the company is in compliance with the requirements of Federal health care programs.

**Northside Hospital Settles Whistleblower Lawsuit**

Atlanta's Northside Hospital will pay \$5.7 million, and two physician-owned entities will pay \$650,000, to settle claims that they violated the False Claims Act by submitting claims to the Medicare program with illegal financial and referral relationships.

The claims allege that Northside provided services free of charge. Of that amount, the two "whistleblowers" in the case – former BMTGA employees Cheryl Burns and Janine Slaughter – will jointly receive \$1.2 million as a share of the recovery under the settlement, according to the U.S. Attorney.

Although agreeing to pay the settlement and related amounts, Northside expressly denied any liability, fault, or wrongdoing.

**OIG Issues Six Advisory Opinions in Five Weeks**

The OIG has issued six Advisory Opinions since October 1, 2006. Covering a wide range of fraud and abuse issues, the OIG addressed concepts that specifically target DME company marketing proposals. Furthermore, the Advisory Opinions reflect an increasing willingness by the agency to review applications on a regular, timely basis and to support provider efforts to increase access to underserved populations.

Due to space constraints, included below are only brief descriptions of each Advisory Opinion, along with links to the B&B website.

Advisory Opinion 06-20 - negative opinion regarding a durable medical equipment supplier's practice of providing patients with free home oxygen until the patients qualify for Medicare coverage of oxygen, as well as the supplier's proposed arrangement to provide patients with a free overnight oximetry test. Issued November 8, 2006. To view article, click here.

Advisory Opinion 06-19 - positive review of a pharmaceutical company's proposal to establish a patient assistance program to provide outpatient prescription drugs to financially-needy Medicare Part D enrollees entirely outside of the Part D benefit could potentially generate

prohibited remuneration under the fraud and abuse laws. Issued November 2, 2006. To view article, click here.

Advisory Opinion 06-18 - positive analysis of a volunteer services program for the provision of specialty medical care and professional development in rural areas, through which volunteers' travel costs would be covered. Issued November 2, 2006. To view article, click here.

Advisory Opinion 06-17 - positive review of payment of certain compensation owed by the organizer of a dental preferred provider organization to a dental network marketing and management company in connection with the use of the dental network by a Federal employee health benefits plan. Issued October 13, 2006. To view article, click here.

Advisory Opinion 06-16 - negative opinion of a proposed arrangement for a durable medical equipment ("DME") manufacturer to provide advertising assistance and reimbursement consulting services to some of its customers. Issued October 10, 2006. To view article, click here.

Advisory Opinion 06-15 - positive opinion of an arrangement under which a managed care company will disburse pay-for-performance financial incentives on behalf of a State's Medicaid program. Issued October 6, 2006. To view article, click here.

**TAX ISSUES**

**Mississippi Hospitals Go to Court to Block Medicaid-Related Tax, Cite Extreme Burden**

JACKSON, Miss.--A group of 43 Mississippi hospitals and the Mississippi Hospital Association sued Gov. Haley Barbour (R) and the state's Medicaid program Sept. 21, asking a state court to block collection of a tax on hospital gross revenues assessed by the governor (King's Daughters Medical Center v. Barbour, Miss. Chancery Ct., No. G2006-1621, filed 9/21/06).

The lawsuit, filed in state chancery court in Hinds County, follows more than four months of lengthy negotiations regarding how the state funds the program, which is facing a shortfall in money.

Plaintiffs contend that only the legislative branch of government can levy taxes. They allege that the levying of the tax oversteps the constitutional authority of the executive branch. Under a letter of agreement between the



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hospitals and the State, the State had until September 20 to gain federal approval for an alternative proposal.

## PRIVACY

### **Georgia Disclosure Law Preempted by HIPAA, Appeals Court Rules**

The Georgia Court of Appeals recently held that an important component of last years' tort reform legislation, requiring authorizations from medical malpractice plaintiffs, is preempted by HIPAA. The court agreed with the trial court and plaintiff Linda Queen that a state law requiring her to sign a broad disclosure authorization before proceeding with her claim against Northlake Medical Center was preempted by the privacy law. Northlake argued that the Georgia law was not preempted by HIPAA because it did not "contravene" HIPAA and because it was possible to comply with both laws. However, Queen argued that the law was preempted because it did not require "the elements necessary for a valid authorization under HIPAA", and the appeals court agreed.

## HEALTH INSURANCE

### **Alabama High Court Dismisses Two Claims, Reinstates One in Premium Payment Dispute**

On October 20, the Alabama Supreme Court reinstated a physician's claim for breach of contract, ruling a state trial court should not have decided summarily the amount of his malpractice insurance premium a hospital had agreed to pay under an employment contract (Hooper v. Columbus Regional Healthcare System, Ala., No. 1031128, 10/20/06).

Dr. Dwight Hooper, an obstetrician-gynecologist, entered into a three-year employment contract with Columbus Regional Healthcare System (Columbus). The contract required Columbus to provide Hooper with privileges at two hospitals, and to pay Hooper's professional liability insurance premiums at the "standard rate". At the time, Hooper's premiums were approximately \$15,000.

Following a medical malpractice case against Hooper and Columbus, Columbus informed Hooper that his professional liability insurer would not renew his policy, and advised Hooper to find a new insurer that would offer non-standard-rate coverage.

In concluding that the breach of contract claim had to be reinstated, the court said Hooper

presented evidence that indicated Columbus Regional may have breached the employment agreement first "when it refused to pay the standard-rate premium of \$36,510," as quoted by broker Parker Harvey for physicians in similar practices in Columbus, Georgia.

Hooper sued Columbus for breach of contract, wanton and/or willful conduct, and civil conspiracy. Following extensive discovery, the trial court ruled in favor of Columbus and Hooper appealed.

Hooper argued that Columbus breached the employment agreement by failing to pay its share of Hooper's insurance premium – the \$36,510 quote for physicians in similar practices in the area.

The court examined the contract, which provided that if Hooper's premium exceeded the standard rate, Columbus would pay "that sum which is the insurer's standard premium rate for physicians in similar practices in Columbus, Georgia." Because this language supported Hooper's position, the trial court erred when it entered summary judgment for Columbus on the breach of contract claim, the high court concluded.

### **Georgia Receives Federal Approval To Offer Health Coverage Tax Credit**

Gov. Sonny Perdue and Blue Cross and Blue Shield of Georgia Inc. announced Oct. 30 that the state has received approval from the Internal Revenue Service to participate in the federal government's Health Coverage Tax Credit program.

The program provides financial assistance for providing health insurance to state residents who have lost their jobs as a result of foreign trade issues or whose pension plans are underfunded.

Perdue said that under the program, qualifying individuals can receive 65 percent of their annual insurance policy premium from the IRS but must pay the remaining 35 percent.

BCBS of Georgia began offering policies to state residents who meet the IRS eligibility requirements. According to the BCBS plan, the state's largest health insurer is now offering four individual health care plans under the tax credit program.

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## EMTALA

### Federal Court Dismisses Remaining Claims In Lawsuit Over Alleged Failure to Stabilize

A federal trial court ruled on October 12 that a woman who claimed a hospital discharged her husband before he was stabilized did not prove a claim under the Emergency Medical Treatment and Labor Act, (*Morgan v. North Mississippi Medical Center Inc., S.D. Ala., No. 05-0499-WS-B, 10/12/06*).

North Mississippi Medical Center Inc. received summary judgment in a lawsuit brought by the spouse of a man who died shortly after being returned to his home. Although the U.S. District Court for the Southern District of Alabama in December 2005 refused to dismiss the failure-to-stabilize claim on a motion to dismiss filed by NMMC, the court found that summary judgment was now appropriate based on the evidence presented.

The court specifically found that the plaintiff did not prove her EMTALA claim and that her claim alleging outrageous conduct was either time-barred or involved circumstances that did not satisfy the "formidable threshold" for such claims under Alabama law.

The court, in entering a judgment for NMMC on the EMTALA claims, said there was no question that her husband was screened, diagnosed, and admitted for nine days and that Morgan failed to show that he was admitted in bad faith merely as a way of avoiding EMTALA liability.

Noting that EMTALA is not a federal-law substitute for medical negligence claims under state law, the court said NMMC stabilized the conditions it diagnosed even if it did not diagnose all of the injuries that the patient suffered.

## CERTIFICATE OF NEED

### New Certificate of Need Application Fee and Monetary Threshold for Review in Alabama

The expenditure threshold for major medical equipment will be increased from \$2,208,800 to \$2,277,273; as of October 1, the new annual operating cost will be increased from \$883,520 to \$910,909; and any other capital expenditure by or on behalf of a healthcare facility or health maintenance organization will be increased from \$4,417,599 to \$4,554,545, according to SHPDA.

Based on a 3.1% increase in the CPI, the maximum Certificate of Need filing fee, effective October 1, 2006, will be increased from \$16,819 to \$17,340.

## Alabama Approves CON for CyberKnife

On September 20, 2006, Alabama's Certificate of Need Review Board approved the issuance of a CON for the acquisition and operation of Alabama's first CyberKnife. The CON was granted to CyberKnife of Birmingham, LLC, a company owned by Swaid Swaid, M.D, who is a neurosurgeon in Birmingham. Dr. Swaid also chairs the CON Review Board, but he recused himself from considering the CyberKnife's CON application.

A CyberKnife is a stereotactic radiosurgery system similar to a GammaKnife. Unlike traditional radiosurgery systems (such as the GammaKnife) that can only treat tumors in the head and neck, the CyberKnife can treat both intracranial and extracranial tumors. The CyberKnife is a lightweight linear accelerator coupled to a robotic arm that delivers precise focused beams of radiation designed to treat tumors and lesions anywhere in the body with sub-millimeter accuracy. Using image guidance technology and computer controlled robotics, the CyberKnife is designed to continuously track, detect and correct for tumor and patient movement throughout treatment. Because of its extreme precision, the CyberKnife does not require invasive head or body frames to stabilize patient movement, vastly increasing the system's flexibility. The CyberKnife System provides an additional option to many patients diagnosed with previously inoperable or surgically complex tumors.

As reported in a September 21, 2006 article in the *Birmingham News*, Dr. Swaid would like to partner with local hospitals to operate the CyberKnife venture.

## COMMENTARY

### The Danger of Avoiding Peer Reviews

An out-of-state hospital sends a standard credentialing form asking about the work history of a physician who used to have staff privileges at that hospital. The staff sends back a standard letter stating the beginning and ending dates of his staff privileges and nothing else. After the physician commits malpractice, his new hospital sues. The jury finds the hospital liable for millions of dollars even though the hospital never conducted a peer review that produced any finding of subpar practice. Can this really happen? Yes.



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A federal court in Louisiana entered a jury verdict against Lakeview Regional Medical Center (“Lakeview”) in Covington, Louisiana, for over \$2 million this year for just such a failure. Lakeview had noticed something odd about Dr. Berry’s Demerol prescriptions. Plaintiff’s counsel contended that Lakeview’s hospital administrator and the head of the anesthesiologist group that employed Dr. Berry had conducted an informal investigation. While not officially suspending Dr. Berry’s clinical privileges, they required him to go through an action plan to prevent future Demerol problems. Later, Dr. Berry failed to answer while on-call one night and was sent home after appearing groggy. The anesthesiologist group, which had an exclusive contract with Lakeview, terminated Dr. Berry for cause. Lakeview then allowed Dr. Berry’s staff privileges to expire. Lakeview initiated no peer review proceeding and reported nothing to the National Practitioner Data Bank.

Several months later, Lakeview received a credentialing questionnaire from Kadlec Hospital (“Kadlec”) of Richmond, Washington. Lakeview responded with a letter stating, “Due to the large volume of inquiries received in this office, the following information is provided . . .,” and then listed the start and end dates of Dr. Berry’s staff privileges. Kadlec did not call Lakeview or follow-up in any way. The dates listed for staff privileges turned out to be incorrect, thus not revealing a six-month gap between their termination of Dr. Berry’s staff privileges at Lakeview and his application with Kadlec.

There was nothing in the National Practitioner Data Bank or the letter from Lakeview to raise Kadlec’s suspicions. Kadlec extended privileges to Dr. Berry. Dr. Berry subsequently was involved in an incident that resulted in permanent brain damage to a female patient. Malpractice litigation ensued in which Dr. Berry admitted his addiction to Demerol. Kadlec settled with the patient and her family for over \$7 million. Kadlec and its insurance company then sued Lakeview and several doctors from its anesthesiologist group for causing its loss through negligent and intentional misrepresentation of Dr. Berry’s credentials.

Kadlec’s credentialing manager testified that had she seen that Dr. Berry had lacked staff privileges for several months, the credentialing process would have stopped immediately and Kadlec would not have hired him. Kadlec further argued that while Lakeview sent a short letter in response to its credentialing request on Dr. Berry, Lakeview’s staff had completed full questionnaires in response to credentialing requests made by other hospitals regarding other physicians.

Lakeview countered that it was not under a duty to provide Kadlec with additional, negative information, especially when Kadlec did not call or follow-up with a request for additional information. Indeed, Lakeview believed it could have been exposed to a defamation suit by Dr. Berry had it conveyed such information and it had been inaccurate. The federal judge, however, did not buy Lakeview’s arguments and sent the case to the jury.

The jury awarded Kadlec over \$2 million in damages against Lakeview and additional damages against other defendants. The case is now on appeal to the United States Court of Appeals for the Fifth Circuit, which hears federal appeals from Mississippi, Louisiana, and Texas.

A lesson to be taken home is that when there is a quality of care problem with a physician, it can be dangerous to avoid peer review and reporting. The Health Care Quality Improvement Act (“HCQIA”) requires a hospital to report a professional review action based on the “competence or professional conduct of a physician” where clinical privileges and patient welfare could be affected. This is a big step. The hospital, peer review committee, and board of trustees must make sure that the physician, who is under review, receives the procedural protections afforded him by HCQIA, state law, and the applicable by-laws at every step of the review process. When these steps are taken with care, the hospital can stand in a better -- good faith -- posture if it is sued after one of its former physicians commits malpractice elsewhere.