

FLURRY OF PROPOSED REGULATIONS AND LEGISLATION
LIKELY TO CREATE NEW HARDSHIPS FOR PHYSICIANS

By: Steven I. Kern

The new year has gotten off to a bad start for most New Jersey physicians. Regulators and legislators are seeking to eliminate traditional reimbursement formulas, prohibit co-management of patients, restrict physician-owned, single operating rooms, and yet again redefine appropriate business practices. A copy of each of the proposed regulations and legislation can be found at the Kern Augustine Conroy & Schoppmann website B www.drlaw.com. For more information, contact Steven Kern directly at sikern@drlaw.com.

USUAL CUSTOMARY AND REASONABLE B NO LONGER?

A proposed regulation by the NJ Department of Banking and Insurance (DOBI) could force many out-of-network physicians and facilities to close their doors. The proposal would limit the amount of money a third party payor would have to pay out-of-network providers to 90% of Medicare=s reimbursement rates and eliminate the traditional AUsual Customary and Reasonable@ reimbursement formula.

Specifically, the proposal would require carriers to recognize charges by out-of-network providers only up to 150% of Medicare=s reimbursement rate. It would also allow carriers to require patients to pay up to 40% of the allowable amount. As such, the carrier would only be responsible for 60% of the 150% recognized, or 90% of the Medicare charge. The out-of-network physician or facility would then have to collect the 40% co-payment from the patient, along with any charges which exceed 150% of Medicare.

The practical implication of this regulation, if adopted, is that most physicians and facilities would be unlikely to be able to balance bill patients much beyond 150% of Medicare and that reimbursement rates for out-of network services would be severely eroded. Of note is the fact that hospital reimbursements are specifically excluded from the proposed regulation.

Physicians and patients can submit comments on the proposed rule to Robert Melillo, Legislative & Regulatory Affairs, 20 W. State St., PO Box 325, Trenton, NJ 08625-0325; fax: 609-292-0896; email: LegsRegs@dobi.state.nj.us. The comment period has been extended to April 2, 2007.

Kern Augustine is suggesting that physicians contact both DOBI and their State legislators, expressing strong opposition to the proposed regulation. Also, physicians may wish to ask their patients to send a letter to DOBI and their State legislators as well. Proposed language for patients could include:

I have elected a medical plan which gives me the option of going to out-of-network physicians and facilities because that choice is important to me and my family. I understand, however, that a new regulation will make it more costly for me to do so because it will reduce the amount that my medical plan has to pay, therefore increasing the cost to me.

While the Governor is trying to reduce property taxes, this regulation will simply create another State mandated burden -- this one on healthcare costs.

For the health of New Jersey, please withdraw this proposed regulation.

While the proposed regulation creates enormous problems for many providers, DOBI argues that the lack of any regulation would be even worse. According to DOBI, recent filings by third party payors reflect an effort on their part to reduce reimbursements to out-of-network providers by even more than the amounts proposed by DOBI. DOBI argues that, absent a regulation, the payors will simply change the definition of Usual Customary and Reasonable or eliminate it from their policies, altogether. One effort that payors may use to redefine Usual Customary and Reasonable is to simply change the definition from the amount usually and customarily charged by a physician to the amount usually and customarily paid by the third party.

Because of this concern, simply defeating the proposed regulation will likely not be enough. Efforts must be undertaken to assure that payors continue to provide reimbursement to out-of-network providers using the traditional Usual, Customary and Reasonable formula.

CO-MANAGEMENT

DOBI is not the only agency looking at payment issues. The New Jersey Board of Medical Examiners is proposing a new regulation that would prohibit surgeons from co-managing patients with other health care providers, in most circumstances. The proposed regulation, *N.J.A.C. 13:35-4.3*, generally would prohibit a surgeon from delegating post-surgical care to non-physicians. It would also eliminate any global fee-sharing for post-operative co-management of the patient.

With few exceptions, post-operative care may be referred to another non-physician healthcare provider under the proposed regulation only when:

1. The referral is clinically appropriate.
2. Parties receive no payment from each other for the referral.
3. The only exchange of value between the operating surgeon and the non-physician is the remuneration each receives directly from third party payors or the patient as compensation for the services each has furnished to the patient.

The prohibition does not apply when the non-physician healthcare provider works in the same professional practice structure as the surgeon, the surgeon and the non-physician are in an affiliation, collaborating relationship or supervision relationship pursuant to regulation, or the non-physician is a physician assistant, midwife or advanced practice nurse employed by the healthcare facility in which the surgery takes place.

ONE-OR SUITES

Currently, physicians may operate in one-operating room surgical suites operated by physicians in their private offices without the surgical suite being licensed by the state. Facility fees can be billed

so long as the suite is Medicare certified.

Legislation (S2394, A3877) has been introduced in the NJ Legislature which would require licensure by the NJ Department of Health and Senior Services for these one-operating room surgical suites and impose additional regulation by the NJ Board of Medical Examiners. Existing surgical practices would have one year to obtain licensure, though a great many would likely be unable to meet the higher standards.

CHANGE IN PRACTICE STRUCTURES

Another proposed regulation by the Board of Medical Examiners, *N.J.A.C. 13:35-12.1 et seq*, defines appropriate professional practice structures and prohibitions on kickbacks and limitations on self-referrals.

The proposed regulation often, but not always, follows federal standards, thus making this complex area of the law even more difficult to comprehend.

Among the more significant requirements are the following:

A physician practice structure can include only closely allied professionals B defined only to include licensees of any branch of medicine and surgery, opticians, optometrists, physical therapists, registered professional nurses and dentists.

Any physician practice structure which includes these closely allied professionals must assure that at least one of the practitioners with the least limited scope of practice shall personally and regularly provide patient care services at each location operated by the entity for at least eight hours per week or that at least one-third of that practitioner=s practice income is derived from performance of procedures at that location.

Joint ventures must comply with federal and state law (including the requirement that at least 60% of an entity=s investment interests are held by persons not in a position to refer to, provide services to, or otherwise generate business for the entity). If the joint venture involves a licensed health care facility, it must also maintain a continuous quality improvement program and utilization management program, with periodic reports made available to the Board.

Every professional practice must have written documentation designating a practitioner who will be responsible for the cleanliness of the office, medical waste, equipment maintenance, credentialing, record maintenance and auditing, drug maintenance, billing and advertising, and fees.

A practitioner cannot refer to a healthcare entity in which he or an immediate family member (defined to include spouse, child, sibling, parent, spouse=s sibling, spouse=s parent, children=s spouse) has a financial interest, unless grandfathered (before 7/31/91); the service is one of three statutorily exempted services; the service is provided at the practitioner=s medical office; or the practitioner can demonstrate that the arrangement satisfies the exceptions set forth in the Stark Law.

A physician who refers a patient to a health care entity in which the physician has a financial interest must not only provide referred patients with the statutorily required disclosure notice but must have the patient sign and date the notice for the medical record.

An ambulatory surgical center may be considered a practitioner=s medical office only if it complies with the federal ASC safe harbor and additional Medical Board requirements which are far more restrictive than current federal requirements.

CONCLUSION:

Needless to say, these proposed regulations and legislation could have enormous impact upon the practice of medicine. Kern Augustine is carefully monitoring developments in each of these areas, and is working with a number of physician and other organizations to address the issues they raise.