Electronic Transactions Standards Compliance Deadline is Quickly Approaching

By Nancy M. Weinman, Esq., Montgomery, McCracken, Walker & Rhoads, LLP

Failure to comply by October 2002 may cause exclusion from Medicare

Hospitals, nursing homes, physicians and other healthcare providers who transmit any health information electronically cannot afford to ignore the deadline for complying with new national electronic data exchange standards. The standards created under HIPAA Electronic Health Care Transactions and Code Sets cover the electronic format of bills submitted to payors and require providers to use uniform national code sets (e.g., CPT, ICD-9). The deadline for covered entities to comply with these national standards is Oct. 16, 2002. There is not very much time to make the many changes that will be required.

In response to concerns expressed by many covered entities that there was inadequate time to make the required changes, Congress has given providers an opportunity to apply for a one-year extension from the October 2002 deadline. Providers who want an extension must submit a form to the U. S. Department of Health and Human Services (HHS) no later than Oct. 15, 2002.

The extension form approved by Congress requires providers to state the reasons for requesting the extension, to estimate the cost of compliance, and to identify the steps they will take to achieve compliance as well as the projected start and completion date for each step. HHS also wants providers to give notice if they will be using a contractor or a vendor to achieve compliance, and to indicate when they will test their transactions. Testing must begin no later than April 16, 2003.

How will a covered provider know whether other entities with which it does business (referred to as its "trading partners") have requested extensions? Each provider should communicate directly with its own trading partners to determine which ones have submitted extension requests. This information should be taken into account when establishing testing schedules.

A covered entity that has neither filed for an extension nor achieved compliance with the new standards by Oct. 15, 2002, may be excluded from participation in the Medicare program.

The HIPAA law prohibits HHS from paying Medicare claims that are not submitted electronically after Oct. 16, 2003, unless the provider obtains a waiver from this requirement. To date, no regulations have been published to set forth ground rules on requesting or granting such waivers.

The American Medical Association encourages all physicians to file for the extension request as quickly as possible. The additional year will allow physicians to modify their administrative practices and test those changes in transactions with health plans and insurers. As a general rule, we recommend that all covered entities ask for the extension. Even if a covered entity believes it will be in compliance by Oct. 16, 2002, the extension affords an additional year to work out the "kinks" and to respond to any last minute changes in the regulations.

Must each physician in a group practice file a separate extension request? Not if the practice files all claims on the physicians' behalf. Any physician who submits claims for payment outside the group's billing system, however, will need to file his or her own extension request form.

The extension form can be found on the HHS Web site at www.cms.hhs.gov/hipaa. The form can be filed electronically or on paper.
Pennsylvania Society for HealthCare Attorneys Joins PBA Health Care Law Committee

By Lee W. Doty, Esq., Montgomery, McCracken, Walker & Rhoads LLP

Last spring, the Board of Directors of the Pennsylvania Society for Health Care Attorneys (SHA) voted to join forces with the Health Care Law Committee of the Pennsylvania Bar Association (HCLC). This decision came several months following notice from the Hospital & Healthsystem Association of Pennsylvania (HAP) that it could no longer provide support services to SHA and certain other affiliated societies. Although the notice was somewhat unexpected, SHA had for some time been considering whether it could more effectively pursue its mission by joining another organization with similar goals.

As a first step, the SHA Board asked Christopher Markley, President of SHA and Senior Vice President of Community and Governmental Relations of Pinnacle Health System, and the author, President-elect of SHA and Chair of the Health Law Practice Group, at Montgomery, McCracken, Walker & Rhoads, LLP, to explore an affiliation with Widener University School of Law, with whom SHA has annually sponsored the Reed Hamilton Memorial Lecture, a law student scholarship, and other activities. Although interested in continuing the joint programs, Widener did not feel well suited to sponsoring SHA.

The SHA leadership was also asked to contact Tom Blazusiak, Chair of the HCLC, to see if there were advantages for both groups in joining forces. A preliminary discussion made it clear that the HCLC and SHA were a good match. First, the two groups overlap substantially in terms of membership. In addition, the two groups focus their education programs primarily on state law issues, filling the void left by national organizations such as American Health Lawyers’ Association and the American Bar Association Health Law Committee.

There are some differences, however. SHA is a dues-paying organization and the HCLC is not. Moreover, HCLC members specialize in diverse areas of health law, ranging from medical malpractice to long term care, while SHA members concern themselves primarily with hospital and health system issues. Since PBA manages the diversity of its members through active subcommittees, it was agreed that SHA could continue its focus on hospitals as well as preserve its traditions and autonomy by forming its own “hospital and health system” subcommittee.

Important to the SHA Board in approving the move was the ability to continue to control the funds SHA has collected in dues from its members over the years in order to continue to award the scholarships and conduct other programs in the future. According to Mr. Blazusiak, PBA and HAP, this will pose no problem.

Don’t Miss the Health Care Law Committee Meeting on Nov. 21

The Health Care Law Committee will meet during the PBA Committee/Section Day on Nov. 21 at the Holiday Inn East in Harrisburg. For more information, please check the PBA Web site, www.pbar.org.

This is the place to be for all Pennsylvania health care attorneys!
On Aug. 14, HHS published final modifications to the privacy regulations. The changes are intended to correct unintended consequences of the final regulations, published in December 2000, that threatened patients' access to, or the quality of, health care. The modifications touch on five of the key policy areas addressed by the final regulations, including consent, research, marketing, notice and business associates. The final modifications do not impact the pending compliance dates. Most covered entities – health care providers, health plans and data clearinghouses – have until April 14, 2003, to comply with the patient privacy rules; under the law, certain small health plans have until April 14, 2004, to comply.

More specifically, HHS made the following revisions to the final privacy regulations:

- **Remove Consent Requirement and Strengthen Notice Provisions.** The final rule promotes access to care by removing the consent requirements for treatment, payment and health care operations that could interfere with efficient delivery of health care, while strengthening requirements for providers to notify patients about their privacy rights. Providers must make a “good faith effort” to obtain a patient’s acknowledgement of the privacy notice, but doctors and other providers can treat patients if they did not provide the acknowledgement. This change is intended to ensure that patients can consider a provider’s privacy policies before making health care decisions, but eliminates barriers to patients’ access to care.

- **Strengthen Parental Access to their Children’s Health Information.** The final rule may have unintentionally limited a parent’s access to their child’s medical records. The change clarifies that state law governs disclosure to parents. In cases where state law is silent or unclear, the revisions preserve state law and professional practice by permitting a health care provider to use discretion to provide or deny a parent access to such records as long as that decision is consistent with state or other law.

- **Clarify Marketing Restrictions.** The final rule would prohibit use of protected health information for marketing, while allowing appropriate communications. Based on consumer concerns that the marketing provisions were ineffective to protect patient privacy, the proposal would explicitly require pharmacies, health plans and other covered entities to first obtain the individual’s specific authorization before sending them any marketing materials. HHS believes that requiring authorization for all marketing communications would effectuate greater consumer protection not currently afforded by the disclosure and opt-out conditions under the current regulations. The final rule redefines “marketing” as “to make a communication about a product or service to encourage recipients of the communication to purchase or use the product or service.” Essentially, if the effect of the communication were to encourage recipients of the communication to purchase or use the product or service, the communication would be “marketing,” regardless of the actual intent of the speaker. The final rule makes clear that a covered entity is prohibited from selling patient or enrollee lists without appropriate authorization. At the same time, the rule continues to permit doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

- **Research Consent Forms.** The final rule eliminates the need for researchers to use multiple consent forms – one for informed consent to the research and one or more related to information privacy rights. Instead, researchers can now use a single combined form to accomplish both purposes.

- **Model Business Associate Provisions.** The final rule includes model business associate contract provisions, making it easier and less costly for covered entities to implement the requirements. These provisions are intended only as model language to help covered entities comply with the privacy rule. Use of the proposed model provisions is not required to comply with the privacy rule. Also, the final changes give covered entities up to an additional year to change existing contracts, which is intended to ease the burden of covered entities to renegotiate business associate contracts all at once.

- **Simplify Authorizations.** The changes allow the use of a single type of authorization form to obtain a patient’s permission for a specific use or disclosure that otherwise would not be permitted under the rule. Patients still need to grant permission in advance for each type of use or disclosure, but the change eliminates the need to use different types of forms to obtain that advance permission.

- **Oral Communications and Incidental Disclosures.** The final rule permits a doctor to discuss a patient’s treatment with other doctors and professionals involved in the patient’s care without fear of violating the privacy rule if they are overheard, so long as the covered entity has implemented reasonable safeguards to protect personal health information and the dis-
Final HIPAA Privacy Reg.  
(continued from page 3)

cussions are limited to the minimum necessary information. For example, if these requirements are met, doctors’ offices may use waiting room sign-in sheets, hospitals may keep patient charts at bedside, doctors can talk to patients in semi-private rooms, and doctors may confer at nurse’s stations without fear of violating the rule if overheard by a passerby.

- Hybrid Entities. The final regulations now permit any entity that performs covered non-covered functions to elect to use the hybrid entity provisions and provides the entity additional discretion in designing its health care components.

- Health Care Operations: Changes in Legal Ownership. The new changes also clarify the definitions of “health care operations” to allow a covered entity that sells or transfers assets to, or consolidates or merges with, an entity that is, or will be, a covered entity upon completion of the transaction, to use and disclose protected health information in connection with such transaction, which include due diligence and transferring record containing protected health information as part of the transaction.

- Disclosure for Treatment, Payment, or Health Care Operations of Another Entity. The regulations were modified to clarify that covered entities can disclose protected health information for the treatment and payment activities of another covered entity or a health care provider, and for certain health care operations of another covered entity.

- Protected Health Information: Exclusion for Employment Records. The final regulations clarify that employment records maintained by a covered entity in its capacity as an employer are excluded from the definition of protected health information. The modifications do not change the fact that individually identifiable health information created, received, or maintained by a covered entity in its health care capacity is protected health information.

Finally, the final privacy regulations also include a number of technical corrections and additional clarifications related to various sections of the existing rule.

Medicare Reform

The U.S. House 408-0 approved the Medicare Regulatory and Contracting Reform Act on Dec. 8, 2001. Highlights include allowing repayments in installments and placing limits on carriers use of extrapolation in calculating overpayments.

CMS Agenda

In 66 Fed. Reg. 61555 (Dec. 3, 2001), CMS laid out its regulatory agenda. Highlights include:

a. Standards for electronic signatures (being jointly developed by CMS and the Department of Commerce);

b. Refinedness to the prospective payment system for home health care;

c. Revised conditions of participation for hospitals;

d. The Health Resources and Services Administration will issue a notice of proposed rulemaking in March 2002, to tighten the requirement that the names of physicians and others who pay malpractice claims be reported to the National Practitioner Data Bank;

e. Rules for the initiative to endorse Medicare prescription drugs;


Stark II and HIPAA Delays

In 66 Fed. Reg. 60154, the effective date on the ban of physician referrals to entities which they own was delayed from Jan. 4, 2002, until Jan. 6, 2003. Wording issues were to blame.

The Senate delayed the deadline for compliance with certain HIPAA electronic standards until Oct. 16, 2003.

$1.6 Billion in Civil Fraud Payments Recovered in 2001

The DOJ collected a record $1.6 billion in civil fraud recoveries during fiscal year 2001, with almost three-quarters coming from qui tam lawsuits. Whistleblowers to date have shared $210 million from the recoveries. Healthcare fraud cases accounted for more than $1.2 billion, with the $745-million HCA settlement alone responsible for nearly half the total.

- Rep. John Conyers (D-MI) introduced the Patient and Physician Safety and Protection Act (H.R. 3236), which would limit the shifts of hospital residents to twenty-four hours and to no more than eighty hours a week.

- Edgewater Medical Center, a 215-bed Chicago hospital at the center of a massive fraud investigation, shut its doors in December, one month after its owner from Medicare and Medicaid. Former Vice President Roger Ehmen was sentenced Nov. 28 to six and a half years in prison and ordered to repay $5 million. Several physicians also face prison terms.

- The two Washington, D.C., postal workers who survived inhalation anthrax both were treated with Cipro when they were admitted to Inova Fairfax Hospital. The two who died received Levaquin — thought to be just as effective — when they were admitted to other area hospitals.

- The Occupational Safety and Health Administration (OSHA) issued an updated directive for complying with its standards for avoiding occupational exposure to blood-borne pathogens.
When Good Insurance Companies Go Bad

Reprinted with permission from the May 2002 ACTION KIT for Hospital Law newsletter published by HartySpringer Publications

A number of previously healthy insurance companies have gone into rehabilitation or liquidation recently. One of the most notable is PHICO, which was put into liquidation by the Pennsylvania Insurance Department on February 1, 2002. This unfortunate development has caused many hospitals and physicians to scramble about for insurance coverage that they once took for granted. This article will explain the basics of the insurance rehabilitation and liquidation process, to help providers sort through the confusing choices they will face if insured by a company in financial difficulty.

How have otherwise respectable insurance companies gotten into this fix? There are probably as many opinions as there are insurance salesmen. But the three main culprits seem to be: (1) lower premium rates due to increased competition; (2) declining investment income resulting from the recent poor performance of the stock market; and (3) higher claims costs resulting from more complicated litigation and larger awards. All of this has been exacerbated by the $60 billion hit absorbed by the reinsurance industry as a result of the September 11 terrorist attacks. Put it all together and you have an industry meltdown waiting to happen.

When an insurance company gets into financial trouble, the first step that is usually taken by the insurance commissioner of the state where the insurance company is domiciled is called "supervision." The insurance commissioner works with the insurance company under supervision to try to reverse financial trends that could lead the insurance company to insolvency, usually with a goal toward increasing its reserves. The supervision process is confidential and few outside of the company know that it is happening.

If supervision doesn't work, the next step in the process is known as "rehabilitation." This usually involves a court order enabling the insurance commissioner to assume control of the insurance company, ousting its former officers and directors. The goal of rehabilitation is to try to turn the insurance company around and make it solvent again, or to find out that a turnaround is not possible.

The final step down the road is called "liquidation." This is the equivalent of Chapter 7 bankruptcy proceedings. The insurance commissioner attempts to marshal any available assets to pay creditors a fraction of what they are owed. This process is very complex and often takes years to resolve.

When an insurance company goes into liquidation, a number of things occur. First, all claims payments stop on an insured's policy. It's the same as having no insurance at all.

Insureds need to look to the guaranty association in their particular state to determine what kind of coverage is available. A guaranty association is an association of all insurers licensed to write insurance in each state. Subject to limits set forth in that state's guaranty association law, the guaranty association assumes the policy obligations of the insolvent insurance company. Usually, the "limits" mean that the guaranty association will pay only a relatively small percentage of a claim, leaving the insured responsible for the rest.

Any cases against policyholders covered by the insurance company will be stayed, at least in the state issuing the order. Other state and federal courts will usually, but not always, stay proceedings as well. This allows counsel for the guaranty association to take over the defense of pending claims.

The guaranty association selects counsel, and the insured has no choice in the matter unless it chooses to pay for its own lawyers separately. Guaranty association counsel may not be as sophisticated as previous counsel for the insurance company. They certainly will be paid less per case. The insured should hire its own counsel for any liability not covered.

Coverage by guaranty associations is usually limited. They will cover only insureds in the state where the guaranty association is located. There are also often net worth limits on the guaranty coverage which preclude payment of claims on behalf of insured entities with net worth in excess of a certain amount — usually around $50 million or so. The coverage available from guaranty associations is often low, at or about $300,000 per claim. This can result in a gap in coverage, since excess coverage or coverage provided by catastrophic loss funds to hospitals and doctors often kicks in at higher levels. This gap in coverage would have to be made up directly by the insured.

If an insured has a claim that is not covered by the guaranty association, a proof of claim form needs to be filed with the insurance commissioner acting as liquidator. If the liquidator denies coverage on a particular claim, the dispute goes to a referee and a hearing is held. The referee is usually a judge of the court supervising the liquidation. The hearing is conducted on an informal basis similar to arbitration.

(See When Good Goes Bad on page 8)
MESSAGE FROM THE PAST CHAIR

By Tom Blazusiak, Dept. of Public Welfare

The committee was very active during the last two years. It has held several meetings, sponsored and conducted legal education, conducted several telephone conferences with subcommittee chairs and most notably has entered into a merger with the Pennsylvania Society of Healthcare Attorneys.

Last fall, the committee, in conjunction with the Society of Healthcare Attorneys and the Dauphin County Bar Association, presented an all-day conference on "Hot Topics in Health Law." Topics included: Act 68 Update; Medication Errors; HIPAA/ HHS Proposed Privacy & Security Regulations; Fraud and Abuse Update; and Ethics: Dilemmas in Compliance Investigations & Voluntary Disclosures.

At that conference, The Reed Hamilton Memorial Lecture was delivered by Prof. Barry Furrow of Widener University, School of Law. This lecture is given annually in honor of the late Reed Hamilton, a highly respected Philadelphia health lawyer whose contributions to the bar are widely appreciated.

In May, the committee met in Pittsburgh at the Annual Meeting. We conducted a CLE on "Recent Developments and Hot Practice Tips for Health Care Providers." The CLE included: "Hospital – Physician Competition in the 21st Century" and "Risk Management for Health Care Providers."

At the same meeting, the committee presented its third annual Excellence in Health Care Law Award to John HORTY and Eric Springer of Pittsburgh, two nationally prominent health-care attorneys whose contributions to the profession are widely recognized.

The committee published both a spring and fall newsletter. The newsletters contain features, commentaries and news that members can use on legal developments and upcoming activities. Recent articles have included:

- "Electronic Records and Signatures in Health Care and the Interplay of E-Sign, HIPAA and UETA;"
- "Pennsylvania Legislative Update;"
- "Unanticipated Outcomes Policies for Hospitals: Some Dos and Don'ts;"
- "National Briefs;"
- "PA Department of Health Regulatory Update;"
- "Intermediate Sanctions on Excess Benefit Transactions;" and
- "Managed Care Regulations."

The committee held several teleconferences with its subcommittee chairs regarding upcoming committee activities. Continuing legal education plans are being made in conjunction with Carolyn Wepfer of the Pennsylvania Bar Institute for 2-3 hour sessions at an advanced level. Topics under consideration include: Voluntary disclosure; Risk management and experimentation; Bioterrorism; ERISA; HCQIA; and Confidentiality.

The committee is proud to continue to sponsor the Health Law Institute. Recently the Pennsylvania Bar Association accepted the merger of the Pennsylvania Society of Health Care Attorneys into the Health Care Law Committee. The merger was formally celebrated at the Health Law Institute during our cocktail reception and meeting.

At our upcoming fall meeting, we will discuss plans for upcoming activities including Continuing Legal Education plans for the next year.

We have also had dialogue with other committees including the Specialization Committee, the Elder Law Committee and the Professional Liability Committee on the possibility of joint projects and other areas of mutual concern. We have entered into a collaborative agreement with the American Bar Association’s Healthlaw Section to share articles from each other’s newsletters and have already published articles with ABA permission.

In sum, we are proud of our accomplishments and look forward to the challenges and opportunities ahead.

I thank the PBA and our committee members for the wonderful opportunity to serve as chair for these past two years. It was wonderful. I especially appreciate the help of our previous bar association representative, Jennifer Zimmerman, who has recently finished law school and accepted a position at Rhoads & Simon. Good luck Jennifer! I would also like to thank our vice chair Paul Troy, as well as Paula Sanders whom I succeeded as chair. She was my mentor and remains my good friend.

I leave you in the capable hands of Kim Gray and Lee Doty, who are serving as cochairs, and Paul, who is staying on as vice chair. Help them. Offer your services on subcommittees, the newsletter and with CLE. This is our committee — as with the Army, help it be all it can be. Thanks again.
In a July 12, 2002 opinion, Judge Henry H. Kennedy Jr., United States District Judge for the District of Columbia District Court, granted a motion for summary judgment in favor of co-plaintiffs the American Lithotripsy Society (ALS) and the Urology Society of America (USA), thereby defeating the determination by the Centers for Medicare and Medicaid Services (CMS) that lithotripsy is a “designated health service” under Stark II. American Lithotripsy Society and Urology Society of America v. Tommy G. Thompson, No. 1:01-cv-01812 (D.D.C. 2002).

Lithotripsy services have historically been delivered “under arrangement” with hospitals, in spite of a 1990 determination by CMS that the procedure could be performed in an ambulatory surgery center without a hospital’s involvement. Because CMS has failed to issue a final reimbursement rate for lithotripsy services, and thus preventing lithotripsy centers from billing for them independent of a hospital’s involvement, they continue to be delivered “under arrangement” with hospitals. The hospital typically does nothing more than bill for the lithotripsy services, yet receives up to 70 percent of the Medicare technical fee, even though the majority of lithotripsy centers are owned by urologists, the centers perform nearly all of the work of delivering patient services and the hospital may have no prior or continuing relationship with the patient.

This “under arrangement” relationship has been viewed by CMS as a “financial arrangement” between the urologist and the hospital that would be impermissible unless one of the Stark exceptions is met. Under the Stark Law (42 U.S.C. §1395nn), physicians are prohibited from referring patients to entities with which they have a “financial relationship” (either on the basis of ownership/investment or of compensation) unless they meet one of the exceptions defined in the statute or in regulations.

The Stark Law was modeled after a Florida statute that prohibited all physician self-referrals but that created an exception for lithotripsy services in accordance with a comprehensive study, which demonstrated that physician ownership of lithotripsy centers carried with it a low risk of overutilization, which is the target of the Stark Law. (Judge Kennedy noted, in fact, that CMS had, as recently as 1998, acknowledged the low risk posed by lithotripsy services.) As originally enacted, the Stark Law originally prohibited referrals only to clinical laboratories, but its scope has been significantly expanded through subsequent legislation to include ten “designated health services,” including inpatient and outpatient hospital services.

In its discussion of “inpatient and outpatient hospital services” in the Preamble to the Stark II final regulations, CMS specifically declined to exempt lithotripsy services from its definition, noting “there is no reason to treat lithotripsy any differently than other inpatient or outpatient hospital services.” See 66 Fed.Reg. 856, 940 (Jan. 4, 2001). CMS noted further its belief that “the legislative history [does not] indicate that the Congress meant to exclude [lithotripsy services]” as support for its belief that lithotripsy was meant to be a “designated health service” under the Stark Law. See id., at 941.

Judge Kennedy’s analysis belies CMS’s conclusion, however, as he was able to discern a “clear intent on the part of Congress not to subject lithotripsy to the ban on self-referrals by including it in ‘inpatient and outpatient hospital services.’” Judge Kennedy rejected CMS’s argument that lithotripsy services should be considered “inpatient or outpatient hospital services” merely as a consequence of their being provided “under arrangement” with hospitals. Otherwise, he noted, “any health service with a remote connection to a hospital would be an inpatient or outpatient hospital service.” Further, the Stark Law is conspicuously silent on whether lithotripsy should be considered within its reach, while it specifically mentions other procedures such as magnetic resonance imaging and computed axial tomography. Judge Kennedy further rejected the notion that lithotripsy services meet the Medicare definition of “inpatient services,” as well as CMS’s suggestion that lithotripsy should be considered as “incident to” physician services being delivered to outpatients.

Finding no reason to accept CMS’s contention that the plain meaning of “inpatient and outpatient hospital services” should include lithotripsy, Judge Kennedy reviewed the Stark Law’s purpose and legislative history. As originally drafted, the Stark bill specifically excepted lithotripsy from the blanket prohibition against self-referral, like the Florida statute on which it was modeled. But once the scope of the bill was narrowed to include only clinical laboratory services, there was no longer a need for a specific statutory exception for lithotripsy.
OIG

OIG Advisory Opinions: Donated Space

Advisory Opinion No. 10-19

A public hospital requested if it could donate office space to a non-profit organization that provides "emotional, social, physical and spiritual assistance" to patients with six months or less to live. The charity is not a Medicare-certified hospice. All services are free. It accepts only donations and bills neither patients nor insurers. The OIG recognized that "the vast majority of donors who make contributions to tax-exempt organizations are motivated by bona fide charitable purposes and a desire to help their communities." The OIG opined that the proposed donation "presents a minimal risk of program abuse, while providing significant benefits to a unique patient population."

OIG Makes Corporate Integrity Agreements Less Burdensome

Inspector General Janet Rehnquist explained how she has ordered the reduction of cost, complexity and burden of corporate integrity agreements (CIAs). The following criteria will be used:

- Did the provider self-disclose;
- How much it costs;
- Did the case involve successor liability;
- Is the provider still participating in the program;
- Can the alleged conduct be repeated;
- How recently the conduct occurred; and
- Does the provider have an effective compliance program and would agree to limited compliance or integrity measures and annually certify such compliance to the OIG.

OIG Safe Harbor for Restocking Ambulances

The OIG has established a safe harbor for ambulance restocking. The final rule was published Dec. 3 (66 Fed. Reg. 62979) and took effect Jan. 3, 2002. According to the OIG, the regulation offers protection for the vast majority of ambulance restocking arrangements and insures that emergency medical services are effective. The final rule makes substantial changes, including:

a. allows restocking of ambulances for non-emergency runs so long as the ambulance is also used at least three times a week for emergency runs;

b. restocking of drugs or supplies used by a first responder at the scene of the illness or injury; and

c. it is not necessary to execute a complicated written contract.

When Good Goes Bad (continued from page 5)

Even if a claim is accepted, there is no guarantee that it will be paid. The priority for payment is usually defined in the liquidation statute. The usual priority of claims is (1) administrative claims, (2) policyholder claims, and (3) general creditor claims. There is always a deadline for submitting proof of claim forms, even if the claims are still ongoing. As mentioned above, this process can take up to 10 years or more.

To recover assets to settle claims, the liquidator insurance commissioner will bring suit against third parties. The officers and directors of the liquidated insurance companies are often sued, and sometimes attorneys, accountants and actuaries as well. Legal theories that are relied upon include negligence, fraud, civil RICO, breach of fiduciary duty, fraudulent transfers, and accountant malpractice, especially with respect to reserve calculations.

The liquidator will also pursue "fraudulent transfers" of assets made in the year leading up to the liquidation. So, if you're on the board of a troubled insurance company, caveat emptor.

In order to protect themselves, providers should have some plan in place for seeking backup insurance. They should also carefully review the way their insurance coverage is structured to try to immediately seek coverage from their excess insurance carrier if the primary layer of coverage is provided by an insurance company that goes into rehabilitation or liquidation. This is known as "cut through" coverage.

Hospitals may wish to explore self-insurance alternatives for the primary layer of coverage. They should also review their bond covenants and managed care and service contracts to determine what, if any, level of insurance is mandated by third parties. And, as a last resort, providers may be able to look to the joint underwriters' association for coverage, although the rates and terms are usually less than satisfactory.

The biggest immediate danger resulting from the liquidation of a liability carrier, besides the risk of "going bare," is that a hospital may have to take charges on its financial statement to reserve against potentially uncovered claims. The extent to which this might be necessary is a matter to discuss with the hospital's auditors, who may be gun-shy and ultraconservative as a result of the Enron/Andersen debacle. Suffice it to say that financial statements won't look any better in a year when your carrier goes belly-up.

The health care industry isn't too healthy nowadays. But the specter of failing insurance companies could put many more providers in jeopardy. This is not an easy message to give or to hear. But, it is important to be prepared. Other insurers may follow PHICO!
Nominations Now Open for the 2002 Excellence in Health Care Law Award

The PBA Health Care Law Committee is seeking nominations for its 2002 “Excellence in Health Care Law Award.” As the name implies, this award is given to a health care law attorney whose expertise and professionalism demonstrate the best of our profession. We would like to recognize the recipient at next spring’s Health Law Institute. Nominations must be submitted no later than Dec. 31, 2002.

There are no particular requirements for this award; however, we have included the following suggestions to help you identify your nominee:

- Professionalism
- Participation in health care law activities
- Impact on students of health care law
- Impact on professional development of health care attorneys
- Impact on health care law on a statewide or national basis
- Integrity
- Accomplishments, inside and outside of health care law
- Motivation

Please complete the following and return with letter of nomination by FAX or mail to:

Paul C. Troy, Esquire
Vice Chair, Health Care Law Committee
Kane, Pugh, Knoell & Driscoll
510 Swede Street
Norristown, PA 19401-4886
FAX: (610) 275-2018

Nominations will be accepted until Dec. 31, 2002

Nominee: ____________________________________________________________

Firm, School, Organization: ____________________________________________

Nominated By: ________________________________________________________

Your Address: _________________________________________________________

Your Phone: ___________________________________________________________
Tom Boyle, 2001 Excellence in Healthcare Law Award Recipient

Thomas E. Boyle is a shareholder with the law firm of Buchanan Ingersoll. He is chair of the firm’s Healthcare Law Group and a member of the firm’s board of directors. Mr. Boyle’s healthcare law practice focuses on regulatory and business law matters for healthcare organizations. He has regularly represented hospitals, health systems, home health agencies, skilled nursing facilities, physician hospital organizations and intermediate care facilities for the mentally retarded in administrative and corporate law issues. Mr. Boyle has represented numerous clients in merger or affiliation matters. He serves on The Editorial Advisory Board of Andrews Health Care Fraud Litigation Reporter.

Mr. Boyle has lectured and written on a variety of legal issues in the healthcare field. He has spoken at meetings of the National Health Lawyers Association, National Association of Home Care, the Hospital Association of Pennsylvania Society of Healthcare Attorneys, The Pennsylvania Bar Institute, the Healthcare Financial Managers Association, The Pennsylvania Association of Home Health Agencies, and the Dickinson Law School Forum.

Mr. Boyle’s professional memberships include the Pennsylvania and Western Pennsylvania Societies of Hospital Attorneys and the American Health Lawyers Association. He is a past president of the Society of Hospital Attorneys of Western Pennsylvania and a past president of the Hospital Association of Pennsylvania Society of Healthcare Attorneys. Mr. Boyle has served on a variety of non-profit boards of directors and has been practicing law since 1977. He was formerly associated with the Los Angeles office of a national health law firm and is admitted to both the California and Pennsylvania bars. He has served for over 10 years as an adjunct faculty member at the University of Pittsburgh School of Law where he has taught healthcare law and advanced fraud and abuse law.

Mr. Boyle has regularly been recognized in The Best Lawyers in America in the healthcare law area. In 1994, he also received the Presidents Award from the Pennsylvania Association of Home Health Agencies for outstanding contributions to the home health field.

Authors Needed

This newsletter depends on you for support. Any articles on the practice of health care law will be considered for publication. These articles may be features, current news, historical, editorial, etc. Practice tips are especially useful. Tell us your war stories.

Contact Editor John Washlick at (215) 665-2134 or jwashlick@cozen.com

Name the Newsletter

Proposals for a name for our newsletter are being accepted. Be creative. Send proposals to

John Washlick, Editor Ph: (215) 665-2134 E-mail: jwashlick@cozen.com
Of Interest

Fraud Allegations Settled

The allegations against PacifiCare and its predecessors, FHP International and TakeCare Corp., stemmed from a qui tam suit brought by employee Valerie Fletcher. Fletcher will receive a $3.5 million share of the $87 million award. The settlement is the largest involving health plans that contract with OPM to provide benefits to federal workers and their families.

Third Circuit Reinstates Psychiatric Suit

The Third Circuit reversed a trial court’s dismissal of the Pennsylvania Psychiatric Society’s lawsuit against several plans that manage mental health benefits. The district court said the medical society lacked standing to sue, but the appellate court disagreed in a 2-1 decision. Judge Gary L. Lancaster dismissed the suit for lack of standing. The society contended that the managed care plans refused to authorize and pay for medically necessary mental health treatment and interfered with patients’ care by permitting non-psychiatrists to make treatment decisions.

Medical College of Wisconsin Pays $8.9 Million to Settle PATH Audit

The Medical College of Wisconsin agreed to pay $8.9 million to settle claims that its faculty physicians billed Medicare for services that residents or interns actually performed. The settlement is the latest in a string of the OIG’s Physicians at Teaching Hospitals (PATH) audit initiative.

Hospitals in NY, DC and PA Eligible for $140 Million in 9/11 Funds

The government made $140 million available for hospitals, clinics, blood centers and other providers in New York, Washington, and Pennsylvania areas affected by the Sept. 11 hijackings and attacks on the World Trade Center and the Pentagon. Some $35 million was distributed to healthcare facilities earlier.

The notice of availability of funds appeared in the March 29 Federal Register (67 Fed. Reg. 15206). Grant applications were due in May. The contact is Eulas Dortch of the Health Resources Services Administration, (301) 443-8007, or edortch@hrsa.gov.

Fallout from 9/11: USDA Will Stop Sponsoring Visas for Foreign Doctors

The U.S. Department of Agriculture (USDA) said April 16 that it will help 86 rural communities fund foreign doctors willing to work in rural American under J-1 visas, but it will no longer participate in sponsoring such doctors in the future. The USDA suspended its participation in the program two weeks after the Sept. 11 terrorist attacks, saying it could not conduct adequate background checks.

Only the Attorney General can grant the visa waivers, but the USDA, with its deep involvement in the life and livelihood of rural America, has sponsored 3,100 doctors since 1994, or more than a third.

D.C. District Court Rules

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ripsy. Nonetheless, the Stark Law’s sponsor, in response to a question from another Congressman during coloquy on the Stark bill, confirmed that lithotripsy services provided under arrangement with a hospital was not included in the category of “inpatient or outpatient hospital services.”

These three factors, taken together, were clear evidence of Congress’ intent, according to Judge Kennedy, not to include lithotripsy services within the realm of “inpatient and outpatient hospital services.” Accordingly, he concluded that the CMS regulation classifying lithotripsy as an inpatient or outpatient hospital service under Stark II violates the Administrative Procedures Act and must be set aside.

The case is currently under review by the solicitor general; HHS is reviewing its options with respect to how and whether to pursue the matter further, including whether to appeal Judge Kennedy’s decision.

Judge Kennedy considered facts specific only to lithotripsy services, particularly in his review of the legislative history of the Stark Law and its regulations. The holding in this case is therefore applicable only in the narrow context of lithotripsy services, and should not be interpreted broadly to apply to other healthcare services.
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