Final EMTALA Regulation Brings Significant Changes

By Piper L. Nieters, Esq.
Cozen O'Connor

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted in 1986 to address the perceived problem of a practice commonly referred to as “patient dumping” (refusing treatment of uninsured patients) in hospital emergency rooms. Final regulations were published on September 9, 2003, clarifying the obligations imposed by EMTALA. The final regulations will be effective Nov. 10, 2003. The following discussion provides answers to some of the questions that frequently arise regarding EMTALA.

The original EMTALA regulations left many unanswered questions regarding the definition of an “emergency department.” Under EMTALA, hospitals cannot refuse to assist an individual who “comes to the emergency department” requesting examination or treatment. A substantial criticism of the former regulations stemmed from HCFA’s determination that a person who made a request for care at virtually any place on hospital property would be considered to have presented a demand for care under EMTALA. The new rules define an “emergency department” as a “dedicated emergency department” and identify what other facilities are subject to the law. Under the final regulations, a dedicated emergency department is either (1) licensed by the state as an emergency department or facility; (2) held out to the public as a place that provides care for urgent medical conditions without a scheduled appointment, or (3) that provided at least one-third of all its services on an urgent care basis in the immediately preceding calendar year. The rule also applies to labor and delivery facilities, psychiatric units, and hospital urgent care centers, regardless of whether or not they are located on the main hospital campus. Although EMTALA continues to apply to individuals who present symptoms in areas other than the actual emergency room on the hospital campus, the revisions no longer require off-campus facilities, such as physician offices, nursing facilities, restaurants and shops to comply with EMTALA if they do not meet the definition of a dedicated emergency department.

The final regulations also clarify any confusion created by the original regulations as to what type of care a hospital is required to provide depending on where an individual seeks treatment. Under the new regulations, once a person requests care at a dedicated emergency department, that person must be given an appropriate medical screening whether presenting with an emergency or with a routine medical condition. In contrast, if the person presents symptoms elsewhere on hospital property, such an examination is only required if the person seeks emergency medical treatment.

Additionally, the new regulations address the role of a patient’s insurance information. The rules specify that hospitals may follow reasonable registration procedures prior to the

(See Final EMTALA Reg. on page 4)
Greetings to all!

We hope you had a great summer and that you are managing to stay warm, healthy and happy this fall.

You may recall that at our last meeting, Tom Golden, PBA President, asked for our committee’s assistance in developing “HIPAA Help” for PBA members. In answer to President Golden’s request, our committee came up with a fairly exhaustive list of HIPAA resources. We would like to express our sincere appreciation to those of you who assisted the Health Care Law Committee in developing the HIPAA Resource List for PBA. President Golden was very pleased with our end product, and PBA has received numerous re-publication requests. Special thanks go to Mike Cassidy and Mike Hynum for their stellar contributions. You can see the list on pages 10 and 11 of this newsletter.

We’d like to challenge our committee membership to brainstorm and to suggest similar projects that we might undertake. Beneficiaries of our efforts might include the PBA membership at large, other PBA committees, the provider or payer community, senior citizens, and so on. If you have any thoughts concerning ways in which we might make a difference, please contact one of your co-chairs. We can be reached by email as follows: kimberly.gray@highmark.com or ldoty@mmwr.com.

If you haven’t already done so, be sure to mark your calendars for March 17 and 18, 2004. We’ll be co-sponsoring PBI’s Health Law Institute, being held this year at the Philadelphia Convention Center. This is always an informative and well-attended event, filled with excellent speakers, timely topics and good camaraderie.

Finally, we hope to see all of you at our Committee/Section Day meeting on Thursday, November 20th at 11:00 a.m. And we hope you stay for lunch – networking with other health care attorneys is always a good thing!

Kim Gray, Co-Chair
Lee Doty, Co-Chair

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OF THE HEALTH CARE LAW NEWSLETTER

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“Clear As Mud”: Post-Deadline HIPAA Compliance Confusion Widespread

By William H. Maruca, Esq.
Fox Rothschild LLP

The immediate aftermath of the April 14, 2003, HIPAA compliance deadline for most health care providers suggests that there is still plenty of misinformation circulating among medical practices, hospital medical records departments, health care facilities, providers and suppliers, and others who handle protected health care information (PHI). Notwithstanding the confusion, the Department of Health and Human Services has recently published interim final enforcement rules that indicate HIPAA enforcement is already upon us.

Here is just a sample of HIPAA misunderstandings and myths:

- **Insisting that a Business Associate Agreement is necessary where an appropriate exception applies.** A number of physician groups have received sample Business Associate Agreements from entities with whom no business associate relationship exists under the HIPAA rules, including hospitals, nursing homes, referring physicians, and ancillary providers to whom the physicians refer patients for treatment. Although, as a covered entity, the physician practice is obligated to maintain control over all PHI and handle such PHI in accordance with all the HIPAA regulations, it is not in anyone’s best interest to enter into superfluous Business Associate Agreements.

- **Improperly restricting patients’ access to their own records.** One hospital’s medical records department insisted that a patient specify the dates of service for services rendered nine years ago before agreeing to make copies of those records for the patient to take to a new physicians’ office. When asked why the hospital records clerk could not simply open the chart in her hand and supply the timeframe, the patient was told “this new HIPAA law says we cannot do that.” (This happened to me personally!)

- **Faxes.** The HIPAA Privacy Rule permits physicians to disclose protected health information to another health care provider for treatment purposes. This can be done by fax or by other means. Covered entities must have in place reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information that is disclosed using a fax machine. Examples of measures that could be reasonable and appropriate in such a situation include the sender confirming that the fax number to be used is in fact the correct one for the other physician’s office, and placing the fax machine in a secure location to prevent unauthorized access to the information. Be vigilant! – We are aware of one incident in which 20 pages of PHI were inadvertently sent not to the intended recipient’s fax machine, but instead to a stranger’s text pager because of a misdialed fax number.

- **Discussions with patients’ family members.** If a spouse (or parent of an emancipated child) calls about a patient, the disclosure may be made as if the caller is the patient if, under PA law, the caller has legal authority to act on the patient’s behalf with respect to health care decisions, for instance under a valid health care power of attorney. If the caller is a spouse or parent of an adult child but is not his/her legal guardian and otherwise lacks the authority to make health care decisions for the patient, then the disclosure may still be permitted under the portion of the final rule which allows use/disclosure for the covered entity’s own treatment, payment or health care operations. The final rule allows a covered entity provider to disclose PHI, even when the patient is not present, IF the provider determines, in the “exercise of professional judgment,” that the disclosure is in the patient’s “best interest,” provided that the disclosure is limited to PHI that is “directly relevant to the person’s involvement with” the patient’s care or payment for that care. One example is where the caller is the named subscriber to a health insurance policy calling about a copay billed for services rendered to the caller’s spouse. The safest way to handle family communication issues is to have patients complete an authorization which clearly indicates which family members, if any, the provider is authorized to contact.

- **Required electronic claims.** The Administrative Simplification Compliance Act, passed on Dec. 27, 2001, requires all providers to submit Medicare claims in electronic form beginning Oct. 16, 2003, unless certain exceptions are met. An exception applies to “small providers,” defined as physicians, practitioners, facilities or suppliers with fewer than 10 full-time equivalent employees.

Therefore, small practices that handle all health care transactions on paper will not be dragged into cov-
Final EMTALA Regulations
(continued from front page)

medical examination of the individual as long as they do not delay the patient's screening or unduly discourage individuals from remaining for further examination. However, it is important to note that while the revisions do allow hospitals to contact a patient's insurer for authorization, they cannot do so until after they have completed the initial screening.

Another onerous provision of the former law was its requirement that emergency facilities have certain specialists on-call at all times. Compliance with this provision was especially difficult for small or rural health care providers. However, the new rule relaxes the on-call requirements. Under the new law, a hospital is permitted to (1) maintain a roster of on-call physicians in a manner that is consistent with patients' needs; (2) "share" an on-call physician with nearby hospitals, provided that there are written procedures to handle circumstances when the specialist is not available; and (3) allow the specialist to perform pre-scheduled elective surgery while on-call, so long as it ensures a written policy is in place to provide care when the physician is indisposed.

There are also changes in the law regarding patients who use ambulance services to reach a hospital. Under the current rules, EMTALA applies to a patient in a hospital-owned ambulance but not to patients in non-hospital-owned ambulances that have arrived on the hospital's property. The new law states that EMTALA does not apply to hospital-owned ambulances if (1) the ambulance operates under a community system that requires the patient to be taken to a hospital other than the one that owns the ambulance, or (2) the ambulance is being operated by a doctor not affiliated with the hospital owner.

The original EMTALA rules also failed to specify how they would apply to hospital inpatients. The new rules clarify that EMTALA requirements terminate once a patient is transferred to inpatient care, but notes that EMTALA will still apply in a situation where a hospital does not admit an emergency patient, but then transfers or discharges that patient without meeting the stabilization requirement.

Finally, in light of the heightened concern over emergency preparedness, the new rule suspends sanctions under EMTALA for hospitals in an affected area during a national emergency (such as a bioterrorist attack).

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“Clear as Mud”
(continued from page 3)

edere entity status by reason of the mandatory electronic claims submission if the exception applies. Some organizations have sought to use this mechanism to avoid HIPAA obligations simply by ceasing all electronic transactions effective April 14, 2003. Of course, this only works if the

organizations do not bill Medicare or if they have less than 10 FTEs. It is ironic that a regulatory scheme intended to facilitate electronic communication is having the unintended result of discouraging it.

❍ Charging for copies. The per-page fees authorized under PA Act 26 are still permissible, but “retrieval” fees can no longer be charged by covered entities.

❍ Missing the deadline. Finally, there are some covered entities that let April 14, 2003, come and go without being ready. It is not too late to get compliant, and, in fact, the sooner you take action to meet HIPAA’s myriad requirements the better, since enforcement will be primarily complaint-driven.

Just because you have your privacy notices and business associate agreements in place, don’t think you have covered all the HIPAA bases. Most importantly, get your HIPAA guidance from a knowledgeable attorney, not from the health care “grapevine.”

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Montgomery County Introduces Revised Joint Medical Legal Code of Ethics

On Thursday evening, Sept. 25, the Montgomery Bar Association joined with the Montgomery County Medical Society and District 10 of the Pennsylvania Osteopathic Medical Association in unanimously approving the Fourth Revision of the Montgomery County Medical Legal Code of Legal Ethics.

This joint code, first introduced in 1963 and last revised by the joint Professional Committee in November 1994, sets standards for the interprofessional conduct of doctors and lawyers with the stated goal of protecting and promoting the health and well being of that person the physician calls “patient,” but the lawyer calls “client.”

Topics covered include:
- Medical Reports
- Subpoenas
- Conferences
- Medical Examinations
- Testimony
- Physician Fees and
- Interprofessional Complaints

The Montgomery County Joint Medical – Legal Committee is the oldest continuously active committee in the United States of America. Meetings attended by both doctors and lawyers occur monthly (except July and August) and frequently include a discussion of current issues. Major seminars are jointly produced in the Spring and Fall.

Lee Cowperthwait, chair of the Insured/Managed Care Subcommittee of the Health Law Committee, has been the chief scrivener of each revision and the original code in 1963.

For copies, contact Nancy Hagner of the Montgomery Bar Association, (610) 279-9660 or nancyhagner@montgomerybar.org. For more information, contact Lee Cowperthwait at (410) 639-7406 or kcowper@dmv.com.

Submit your articles for the next issue!

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.

ARTICLES TO BE CONSIDERED FOR THE NEXT ISSUE MUST BE SUBMITTED BY JAN. 15, 2004.

Contact Editor John Washlick
at (215) 665-2134 or jwashlick@cozen.com
Health Maintenance Organizations (HMOs) and Managed Care Organizations (MCOs) have acquired immunity from state law medical malpractice lawsuits, not by a deliberate act of Congress but as an unintended by-product of the Employee Retirement Income Security Act of 1974 (ERISA). Traditionally, insurers were recognized in the health care field as third parties because they were not in need of health care, as was the patient, nor did they supply health care, as did the hospital or doctor, their role was that of “payer,” and they were under no further obligation to the patient and did not have input into medical treatment decisions. That changed with the advent of MCOs, and HMOs and insurers began influencing and often making medical decisions with an eye on economy and little regard for the patient they had never met, escaping liability under the broad protection of ERISA.

Since their inception, the primary objective of MCOs and HMOs has been to curb rising health care costs. They accomplish this through concurrent and prospective utilization reviews, which allow the insurers’ staff nurses and physicians to intervene should the proposed treatment plan be adjudged “unnecessary,” by informing the physician or hospital that they will be denying payment for the services.1 The threat of non-payment provides the insurer with a strong hold on the health care purse strings and great influence over medical treatment decisions. Critics argue that like treating physicians, MCOs are making treatment decisions while, unlike treating physicians, MCOs are given federal protection from liability for the same decisions, thus leaving hospitals and health care providers holding the liability purse strings.

Beginning in 1995, the courts realized that participating in treatment decisions without the counterbalancing accountability that hospitals and doctors were held to had fostered a system where patients were often victimized by treatment decisions that were not in their best interest and they were denied a legal opportunity to redress their wrongs.2 Turning to the express preemption section of ERISA, which states that “the provisions of this sub-chapter … shall supercede any and all state laws insofar as they may now and hereafter relate to any employee benefit plan”3 we recognize now that “in the 1980s and the early 1990s, the Supreme Court had given ERISA preemption a notably expansive scope based on the plain language of this section.”4

In 1995, the U.S. Supreme Court decided New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.5 This was the first in a line of federal cases that initially provided clarity but ultimately left Pennsylvania attorneys more perplexed. In Travelers, the court began to narrow the broad scope of RISA preemption and signaled a change in course, instructing courts to look to the objectives of ERISA, and not solely to the bare “unhelpful language of the statute for guidance in deciding questions of preemption and State law that Congress knew would survive.”6

The 3rd Circuit continued to chip away at ERISA’s enormous breadth in Dukes v. U.S. Health Care,7 holding that insurers make two types of decisions and a claim about the quality of a benefit received is not the same as a claim to recover benefits due under the terms of the plan and thus not preempted by ERISA. Dukes succinctly stated that if the challenge to the health plan was based on quality of care as opposed to quantity of care then ERISA did not preempt the state law claim.

The 3rd Circuit again scrutinized the medical decisions of MCOs, in Shannon v. McNulty8 acknowledging that decisions made by MCOs that limit care must pass the test of medical reasonableness; to hold otherwise would be to deny that the MCO was making medical treatment decisions.9 The Shannon court held that the same duties applied to insurers that applied to hospitals and physicians in making like kind decisions: providing health care; not merely paying for it.10

Still chipping away, the 3rd Circuit followed both Dukes and Shannon in allowing a state negligence claim against an HMO in In re U.S. Health care,11 holding that an HMO made an “essentially medical determination of the appropriate level of care … not a claim that a certain benefit was requested and denied” with regard to their policy of presumptively discharging newborn infants within 24 hours.12 The policy placed the HMO in the “role of provider of medical services” and the claim was not preempted by ERISA as it “fit squarely within the class of claims identified in Dukes as involving the quality of care.”13

(See Age of Managed Care on page 7)

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By Mary E. Fricker, RN, BSN, JD
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Liability for Medical Treatment Decisions in the Age of Managed Care: What’s a Pennsylvania Lawyer to Do?
Age of Managed Care (continued from page 6)

In Pegram v. Heidrich, the U.S. Supreme Court examined the issue once more and although it was an unintended outcome, stated that insurers make a third type of decision - a mixed eligibility and treatment decision. The court held it was not Congress’ intent to allow insurers to act as fiduciaries and make mixed treatment and eligibility decisions and then allow them to avoid accountability for their decisions under the broad protection of ERISA.

The 3rd Circuit was faced with a mixed eligibility and treatment decision in Lazorko v. Pennsylvania Hospital, a claim in which financial disincentives imposed by an HMO discouraged a physician from hospitalizing a patient who later committed suicide. The court found that the physician was influenced by the insurer’s financial incentives to not readmit the patient and the claim was based on the insurer’s decision as to propriety of care rather than administration of care and so was not preempted.

Just when Pennsylvania attorneys thought they saw the light, the 3rd Circuit decided Pryzbekowski v. U.S. Health care, holding that an MCO delay in granting authorization for treatment of a patient by an out-of-network physician was preempted by ERISA. This was difficult for attorneys to reconcile with the court’s prior precedence. The court noted further that this was an eligibility decision which is an administrative decision, and that any state law action based on these types of decisions could be brought by the participant under ERISA §502(a)(1)(B).

The PA Supreme Court confused Pennsylvania attorneys even more in their recent decision of Pappas v. Asbel. The Pappas court held that when an insurer’s utilization review process allows their physician to determine when, where and under what circumstances a participant’s health care will be delivered, they will be held accountable for their decision under state law and the claim is not preempted by ERISA. The Pappas court made clear that accountability for treatment decisions lies with the decision maker.

Pennsylvania lawyers, still reeling from the recent conflicting opinions of two of the highest courts, found themselves in even muddier water when the 3rd Circuit decided the controversial case of Difelice v. Aetna U.S. Health care. The Difelice court allowed an HMO to again escape liability for treatment decisions leaving the treating doctors and hospital once more holding the bag for the insured’s severe injuries. The Difelice court, distinguishing its case from Pegram, where the treating physician was employed by the insurer and thus was the health care provider, noted that “there is no allegation that Aetna actually provided the medical care so Aetna’s use of medical judgment could only have led to an eligibility, not a treatment decision.” The court stated that in “mixed situations” courts are required to decide preemption questions by asking whether the plaintiff could have filed an injunctive suit under ERISA §502(a) to challenge the insurer’s decision.

Judge Becker stated that the lawsuit filed by Difelice pointed out the serious flaws in the approach the courts had taken when deciding whether a claim should be preempted by ERISA and appealed to Congress and the Supreme Court justices to provide guidance to the lower courts, who are “routinely forced to dismiss entirely justified complaints” by plan participants that have been grievously injured by an HMO because of the “unjust and increasingly tangled ERISA regime.” Judge Becker described the case law of the federal court system on this issue as “massively inconsistent due to the sheer complexities of the subject and lack of any meaningful guidance.” There is little doubt that most Pennsylvania attorneys would join in what Judge Becker described as “the rising judicial chorus.”

Endnotes

1 Frank M. McClellan, Medical Malpractice: Law, Tactics, and Ethics, 66 (1994).
2 Wickline v. State of California
3 39 U.S.C. §1144(a)
4 Pappas I, 724 A.2d at 889-91.
5 514 U.S. 645 (1995)
6 Travelers, 514 U.S. at 656.
7 57 F.3d 350 (3d Circuit, 1995).
8 718 A.2d 828 (1998)
9 Cowperthwait at 4.
10 Shannon at 835-6.
11 In re U.S. Health care 193 F.3d 151 (3d Cir. 1999)
12 Id. at 162.
13 Id. at 163, note further that treatment decisions related to level of care are commonplace in utilization review practices in place in hospitals.
14 530 U.S. 211 (2000)
16 245 F.3d 266 (2001).
17 ERISA §502(a)(1)(B) allows a participant to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. Section 502(a)(1)(B) is used when a beneficiary wants to demand benefits that were supposed to have been distributed under the plan. Section 502(a)(3) of ERISA provides for relief separate and apart from that due under the terms of a benefit plan. By its terms it allows beneficiaries to seek “other appropriate equitable relief” to redress (1) a violation of the substantive portions of ERISA or (2) a violation of the terms of the plan.
20 Id. at 12.
21 Id. at 43.
22 Difelice at 73.
23 Id. at 74.
24 Id. at 31.
Third Party Liability – Thorny Issues

By Frances McGinley, Esq. and Kelly S. Curran, Esq.
Cozen O’Connor

Often a patient is covered by two different insurance plans, and the provider must deal with thorny issues such as which insurer is primary and how the patient’s insurance benefits are to be coordinated. When Medicaid is one of the insurers, this decision is governed by federal and state law.

Federal law requires that Medicaid be the payer of last resort and that Medicaid pay only after a liable third party has met its legal obligation to pay. Federal law and regulations require states to assure that Medicaid recipients utilize all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid to pay for all or part of their costs. Federal law requires that Medicaid be provided authority for Medicaid to deny payment for services if the services may be provided or covered by a third party resource, such as an HMO, and the recipient elects to seek treatment from a provider not authorized by the third party resource.

Therefore, if a provider does not participate in a Medicaid recipient’s primary plan, the provider should refer the recipient to the primary plan. If the Medicaid recipient is informed by a provider not authorized by the primary plan that both the primary plan and Medicaid will deny payment for the services, and the recipient then voluntarily elects to receive Medicaid-covered services from that provider, the recipient individually assumes the legal responsibility to pay for the services the same as a private pay patient. The provider, however, must inform the recipient, or responsible adult, before services are provided that they will be financially responsible for the cost of services. Although not required, it would be prudent for the provider to notify the recipient in writing.

Finally, if a Medicaid provider is also a participant in a recipient’s primary plan, the provider must follow the requirements of that plan. If the primary plan denies the claim for failure to follow its requirements, Pennsylvania Medical Assistance will also deny the claim and the provider may not collect from the recipient.

1. If a patient has a commercial plan as his primary insurance under which CHOP physicians (“physicians”) are not participating providers, if the insurer refuses to reimburse out-of-network care, or if the physicians are unable to negotiate a fair rate, and the patient has Medicaid Fee-for-Service as his secondary plan, are the physicians required to accept the Medicaid payment as payment in full, or may they bill the patient for the balance?

Under the above scenario, if Medicaid Fee-for-Service made payment for the services, the provider would be required to accept the Medicaid payment as payment in full and could not bill the patient for any remaining balance. Both Federal and Pennsylvania law and regulation mandate that all payments made to providers under the Medicaid Program “plus any co-payment required to be paid by a recipient shall constitute a full reimbursement to the provider for covered services rendered.” If, however, the total amount of payment by the primary insurer is less than the Medicaid rate for the same service, the provider

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(See Thorny Issues on page 9)
may bill Medicaid for the difference in the rates.\textsuperscript{15} State law only allows a provider to bill a Medicaid recipient for non-compensable services and only if the recipient is told before the service is rendered that Medicaid does not cover the service.\textsuperscript{16} However, if no payment was made by the primary insurer because of failure to abide by plan requirements, Medicaid has no obligations to step up and make payment. See responses to questions 3 and 4 below.

2. If the patient has a commercial plan as his primary insurance with which the physicians do not participate, and that insurer refuses to reimburse out-of-network care or the physicians are unable to negotiate a fair rate, and the patient has Managed Medicaid as secondary insurance, are the physicians required to accept the Managed Medicaid payment as payment in full, with no balance billing to the patient?

As in the previous example, under the above scenario, if Medicaid made payment for the service the provider would be required to accept the Medicaid payment as payment in full and could not bill the patient for any remaining balance. Federal law,\textsuperscript{17} Pennsylvania statute and regulations all mandate that payments made to providers under the Medicaid Program, plus any co-payment required to be paid by a recipient constitutes full reimbursement to the provider for any covered services rendered.\textsuperscript{18} As stated above a provider may only bill a Medicaid recipient for a non-compensable service or item.\textsuperscript{19}

3. What if the Medicaid managed care insurer refuses to allow out-of-network care?

If the physicians are not contracted providers for the Medicaid managed care insurer and the insurer does not allow for out-of-network care, this would be considered a non-compensable service under the Medicaid program.\textsuperscript{20} The physicians could bill the patient for the non-compensable service if the patient is advised in writing prior to the service being rendered that the Medicaid program does not cover it.\textsuperscript{21}

4. A carve out Medicaid mental health vendor stated that if a patient chooses to go out of network from their primary commercial insurer that the Medicaid managed care insurer would be under no obligation to pay the physicians for services. So, based on this, the physicians should be able to balance bill the patient.

The vendor is correct. A 1992 Bulletin issued by the Department of Pennsylvania Welfare entitled, “Billing for Medical Assistance Claims When There Are Additional Third Party Resources,” states:

When a medical assistance recipient has potential medical insurance coverage from another third party resource, the provider must delay billing the Medical Assistance Program until all the other third party resources have been invoiced and settled. When treating a recipient who has coverage under a Health Maintenance Organization (HMO), the provider must follow the procedures stipulated by the HMO policy. The Department will not pay for services denied by an HMO due to provider failure to obtain a proper referral, or failure to follow other HMO procedures. Again, as stated above, in this situation the provider could only bill the Medicaid patient, for the non-compensable service or item only if the recipient is told before the service is rendered that the program does not cover it.\textsuperscript{22}

Finally, for additional clarification, you should be aware of a Pennsylvania Medical Assistance Bulletin that was issued on Sept. 1, 2003. This bulletin deals with a Medicaid recipient’s cost sharing liability when the recipient is covered by a private third party health insurer and Medicaid Fee-for-Service or Medicaid managed care.

\textbf{Endnotes}

\begin{enumerate}
\item 42 U.S.C.A. § 1396a (a)(25)(A),
\item 42 C.F.R. §§ 433 and 447 et. seq.
\item 42 C.F.R. § 433.139.
\item Id. § 433.136.
\item Pennsylvania Medical Assistance Bulletin 99-91-05.
\item Id.
\item 42 U.S.C.A. § 1396a (a)(25)(C).
\item See also 55 Pa. Code 1101.63.
\item Id.
\item 55 Fed. Reg. 1423-03. In certain situations, an HMO may be liable for “out-of-plan” services. For example, out-of-plan providers of services may be reimbursed through the Medicaid agency for covered emergency services for which the HMO assumes financial responsibility. Another example would be if the HMO plan offers out-of-plan services to an individual who needs medical services outside the geographical locality of the plan.
\item See 55 Fed. Reg. 1423-03.
\item 55 Pa. Code 1101.63.
\item Id.
\item Pennsylvania Medical Assistance Bulletin on Additional Third Party Resources Information (February 16, 1987).
\item Id. Most provider contracts contain a provision that prohibits a participating provider from holding an enrollee in the plan liable for payment in the event that the provider fails to follow the plan’s procedures.
\item 62 P.S. § 1406(a) and 55 Pa Code § 1101.63(a).
\item 55 Pa. Code §1101.64.
\item Id. at §1101.63.
\item 42 C.F.R. § 447.15.
\item 62 P.S. § 1406(a) and 55 Pa Code § 1101.63(a).
\item 55 Pa. Code §1101.63.
\item Pennsylvania Medical Assistance Bulletin on Additional Third Party Resources Information (February 16, 1987).
\item 55 Pa. Code § 1101.63.
\item Id.
\end{enumerate}
HIPAA Resource List

**Government**


OCR HIPAA hotline  ⇒  1-866-627-7748

The U.S. Department of Health and Human Services (DHHS) is the leader in insurance reform. DHHS explains HIPAA Title II information on administrative simplification.


The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of HIPAA and the site contains a directory of CMS's business activities with regard to HIPAA.

⇒ http://www.cms.gov/hipaa/

Covered Entity Decision Support Tool Home Page


Questions to Ask Vendors, TPAs, Clearinghouses


HIPAA Resources  ⇒  http://www.cms.hhs.gov/hipaa2/HIPAARESOURCES1PAGER.doc


CMS has developed an e-mail address to seek advice, make recommendations to rule changes, and obtain HIPAA information  ⇒  Askhipaa@hhs.cms.govp

CMS HIPAA hotline  ⇒  1-866-282-0659

National Institutes of Health  ⇒  http://www.nih.gov/

Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs

⇒ www.dpw.state.pa.us/omap/hipaa/omaphipaa.asp

**Forms**

Transaction extension request form & submission  ⇒  www.cms.gov/hipaa/hipaa2/ascaform.asp

Model HIPAA authorization/description  ⇒  www.ama-assn.org/ama/pub/printcat/6900.html

HIPAA Authorization Form  ⇒  www.ama-assn.org/ama/pub/printcat/6695.html


**Miscellaneous**

American Health Information Management Association (AHIMA)  ⇒  http://www.ahima.org/

Journal of American Health Information Management Association  ⇒  www.ahima.org/journal/

AHIMA link for “HIM Body of Knowledge” section that contains “Practice Briefs” (e.g., faxing, provider-patient email security)  ⇒  http://library.ahima.org/xpedio/groups/public/documents/web_assets/bok1_016846.hcst

Related AHIMA Practice Briefs:

⇒ No. 73-1 (Jan. 2002) Understanding the Minimum Necessary Standard
⇒ No. 72-10 (Nov.-Dec. 2001) Required Content for Authorization to Disclose Accounting and Tracking Disclosure of Protected Health Information
⇒ No. 72-6 (June 2001) HIPAA Privacy Checklist
⇒ No. 72-5 (May 2001) Consent for the Use or Disclosure of PHI Notice of Information Practices

The Healthcare Information and Management Systems Society (HIMSS) offers information on current events and compliance dates for HIPAA and a list of nationwide conferences and events on HIPAA.

⇒ http://www.himss.org/hipaasource/hipaasource.asp

HIPAA 96 is sponsored by the Western Midrange Corp. This site offers HIPAA FAQs, the full text version of the act, and various other services.  ⇒  http://www.hipaa96.com/
The American Hospital Association (AHA) advocates issues critical to health care provider organizations in the development and implementation of HIPAA information systems standards. [http://www.hospitalconnect.com/aha/key_issues/hipaa/]

The Washington Publishing Company (WPC) manages and distributes HIPAA’s Electronic Data Interchange implementation guides. These transaction standard implementation guides are available for free in PDF format [http://hipaa.wpc-edi.com/HIPAA_40.asp]

The Workgroup for Electronic Data Interchange (WEDI) provides a forum for HIPAA definitions of standards, resolution of implementation issues and development and delivery of education and training programs. [http://www.wedi.org/public/articles/index.cfm?cat=9]

Association for Electronic Health Care Transaction (AFECHT) [http://www.afehct.org/]

The American National Standards Institute Accredited Standards Committee (ANSI ASC) X12 develops uniform standards for electronic data interchange. The HIPAA transaction rule adopted this organization’s core health care transactions. This site provides information about the X12 committee. [http://www.x12.org/x12org/index.cfm]

This site has various information pertaining to HIPAA including a directory of Practice Management System providers in their resource section. [http://www.hipaa.org]

Consulting and outsourcing sources in healthcare information systems. Sponsor of HIPAAAdvisory, HIPAAAlert and HIPAAlive [www.info@phoenixhealth.com]

Information clearinghouse [www.Rx2000hipaa@rx2000.org]

Guidelines for Academic Medical Centers on Security and Privacy [http://www.aamc.org/members/gir/gasp/]

Health Privacy Project [http://healthprivacy.org/]

Health Privacy Project’s The State of Health Privacy: Summaries of state health privacy statutes [http://www.healthprivacy.org/info-url_nocat2304/info-url_nocat.htm]

Bricker & Eckler LLP Introduction to HIPAA Privacy and Confidentiality [http://www.bricker.com/hipaa/]

Institute for Health Freedom: What Americans Need To Know About Medical Privacy Regulations [http://www.forhealthfreedom.org/Publications/Privacy/NeedToKnow.html]

The Informatics Review: An online journal focusing on clinical computing and medical informatics [http://www.informatics-review.com/]

Web Accessibility Initiative (WAI) [http://www.w3.org/WAI/]

Workgroup for Electronic Data Interchange [http://www.wedi.org/]

To receive email notification on publication of documents related to HIPAA regulations, send an email to listserv@list.nih.gov and include “Subscribe HIPAA-REGS your name” in the body of the message. [listserv@list.nih.gov] [www.hipaalert@lists.hipaalert.com] [www.hipaanotes@lists.hapaalert.com]

**MEDICAL ASSOCIATIONS**

American Medical Association promotes professionalism in medicine and setting standards for medical education, practice, and ethics. [http://www.ama-assn.org/]

Pennsylvania Medical Society represents physicians, supports professional advancement in public health and public policy, as well as in medical science, education, practice, and ethics, and serves as a patient advocate, both on the state and national levels. [http://www.pamedsoc.org/]

American Psychological Association [http://www.apa.org/]

American Psychological Association Practice Organization [http://www.apapractice.org/]

American Psychological Association Insurance Trust [http://apait.org/resources/hipaa/]

American Psychiatric Association [http://www.psych.org/]

Pennsylvania Psychological Association [http://www.papsy.org/]

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