Committee, I have been impressed both by the number of attorneys who are willing to provide service to the bar by taking an active role on this committee and by the number of attorneys who have not done so. I guess the theme of this message then is to ask all of you who are reading this newsletter and who have not been involved in this committee to consider getting involved. The committee provides a great forum to acquire and share information, as well as a voice on numerous issues. We have established subcommittees that deal with practically every hot topic confronting the health lawyer today. The subcommittees are: Risk Management; Long Term Care; Hospitals; Licensing; Behavioral Health; and Government Provider.

I have also found that my time and service to the bar and this committee give me an opportunity to reflect on things that I wouldn’t otherwise think about. I have, for example, realized how vast this field has become since I was practicing plaintiff’s personal injury law in the early 1980s. I also realize how much more highly regulated the health care industry has become since I represented general hospitals in the late 1980s.

My association with this committee has also made me realize how much the practice of law has changed. Lawyers more frequently would not otherwise think about. I have, for example, realized how.

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**Certified Registered Nurse Practitioner (CRNP) Update**

by Kimberly S. Gray – Associate Counsel, Highmark Inc., Co-Vice Chair, PBA Health Care Law Committee

**Current State Law**

The Medical Practice Act of 1985 (MPA) established the State Board of Medicine as the exclusive licensing and disciplinary authority for physicians practicing in Pennsylvania. The MPA addresses such areas as licensing requirements, standards of conduct and the disciplinary process.

The Professional Nursing Law (PNL) established the State Board of Nursing in Pennsylvania. The PNL sets standards for nursing practice, addresses educational and licensure requirements and outlines the disciplinary process for nurses.

The MPA, as amended, regulates the activities of medical professionals in Pennsylvania and permits physicians to delegate to other health care practitioners, including CRNPs, authority to perform certain services. A physician may delegate the performance of a medical service if: 1) the delegation is consistent with the standards of acceptable medical practice embraced by the medical community in Pennsylvania; 2) the delegation is not otherwise prohibited by Board regulations; and 3) the delegation is not prohibited by statutes or regulations governing other licensed health care practitioners.1

A certified registered nurse practitioner (“CRNP”) is a registered nurse (“RN”) licensed in Pennsylvania, who also has been certified by the State Board of Medicine and the State Board of Nursing to function in an expanded nursing role. In Pennsylvania, the Board of Medicine and the Board of Nursing jointly regulate CRNPs.2

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OIG Issues—Final Compliance Program Guidance for Physician Practices

by Robert A. Quigley
Duane, Morris & Heckscher LLP

On Sept. 25, 2000, the Department of Health and Human Services (“DHHS”) Office of Inspector General (“OIG”) issued its final compliance program guidance to assist physicians in solo and small group practices in order to conduct effective voluntary compliance measures to prevent fraud and abuse in federal health care programs. Copies of the final guidance may be obtained on the OIG Web site at www.hhs.gov/oig.

OIG emphasizes that these guidelines, as with the previous ones, are not mandatory, are not all-inclusive, and focus on the individual and small group practices developing meaningful compliance programs that not only adhere to applicable laws, statutes and regulations, but streamline business operations. Compliance programs need not be time- or resource-intensive and should improve the quality of care rendered through improvement in patient care documentation and efficiencies in billing and reimbursement.

One major difference with these compliance guidelines and those issued for other health care entities is that OIG is not suggesting that physician practices implement all seven steps of the guidance. OIG stresses that, although implementation of all seven steps provides a solid basis for a compliance program, this may not be possible for all practices. OIG suggests that, as a first step, physicians identify practice-specific risk areas by reviewing their practices’ history of billing problems and other compliance issues and developing corrective and educational measures to remedy them. In developing these practice-specific compliance programs, OIG recommends that physicians utilize existing resources, such as institutional compliance programs (with hospitals and other facilities), when appropriate, to assist them. By employing a collaborative approach with other health care providers, physician practices can add flexibility and efficiency to their own programs.

Based on the OIG’s investigation and audits involving physician practices, the final guidance identifies the following four specific compliance risk areas:

1. proper coding and billing;
2. provision of services that are reasonable and necessary;
3. accurate documentation; and
4. avoidance of improper inducements, kickbacks, and self-referrals. Individual practice compliance programs should target the risk areas applicable to them.

OIG characterizes a compliance program as preventative medicine for physician practices. By implementing an effective compliance program and incorporating compliance principles into the culture of the practice, physicians will improve their business practices and decrease their exposure to future problems.

Pennsylvania Health Department Issues Report on Adult Behavioral Health

The Health Department issued its 60 page report of more than 3,500 telephone contacts with Pennsylvania adults on the use of services, attitude, health status, etc. involving behavioral health. This study will be used to measure health trends and monitor the effectiveness of the program. It is part of a national campaign by the CDC.

Details on Pennsylvania's report can be found at the department's Web site: www.health.state.pa.us/stats/.

Congressional Activities on Health Care

Democrats and Republicans in the 106th Congress remained at loggerheads on many issues including those involving health care. This has resulted in a significant logjam on many major issues during this session of Congress. Discussions included:

b. Amendment of laws related to privacy.
c. Coverage of prescriptions for medicare.
d. The ever present debates on revisions to managed care.

With the country’s inability at this writing to determine who will be the next president, we probably cannot expect any quick resolution to these thorny issues.

Message from the Chair

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than ever before work for hospitals and health care systems not only as counsel, but as compliance officers, risk managers and in other roles. All of these changes require us to stay on our toes. Participation in the bar association helps us to do this. It makes our practice easier both because of the sharing of information as well as because of the opportunity to share our concerns, questions and war stories with fellow travelers. I urge those of you who are not members of the committee, but who are reading this newsletter, to take this opportunity to join us in this great endeavor.
Since the last update, the following bills have been introduced by the Pennsylvania legislature:

HB 2747 (Readshaw) - An act prohibiting discrimination in insurance coverage on the basis of genetic information or a request for genetic services (Insurance)

HB 2748 (Readshaw) - An act prohibiting certain practices of discrimination because of genetic information (Judiciary)

HB 2788 (Curry) - An act authorizing health care providers to negotiate with health care insurers; and providing for the powers and duties of the attorney general and the insurance commissioner (Insurance)

HB 2789 (Samuelson) - Further defines managed care plan for purposes of quality health care accountability and protection, further providing for the responsibilities of managed care plans (Insurance)

SB 1520 (Holl) - provides for the transfer of the Medical Professional Liability Catastrophe Loss Fund coverage to the private sector (Banking and Insurance)

HB 2685 (Chadwick) - An act providing for health care professional joint negotiation with health care insurers and for the powers and duties of the attorney general (Insurance)

HB 2688 (Dailey) - An act providing for the protection of health care professionals who report inadequacy or quality care in connection with a health care facility and imposing duties on the Department of Health (Health and Human Services)

HB 2690 (Dailey) - An act providing for the duties of nonlicensed health care workers and for enforcement by the Department of Health (Health and Human Services)

HB 2665 (DeLuca) - Prohibits a health care facility from discharging, threatening, demoting, suspending or retaliating against an employee for the filing of a petition, claim or other legal document (Health and Human Services)

HB 2661 (Settler) - Provides for the disclosure to patients by practitioners of the healing arts of the types of health insurance payments accepted, for enforcement and for a civil penalty (Professional Licensure)

HB 2619 (DeLuca) - Amends the Pharmacy Act to provide regulation of pharmacy technicians (Professional Licensure)

HB 2584 (Godshall) - An act amending the Professional Nursing Law, regulating the practice and licensure of dietetics and nutrition; further providing for penalties; and making an appropriation (Professional Licensure)

SB 1452 (Piccola) - An act amending the Professional Psychologists Practice Act further providing for definitions and for temporary license; providing for psychological associates and for private practice school psychologists (Consumer Protection and Professional Licensure)

SB 1447 (Holl) - An act amending the Insurance Company Law of 1921 further defining “insurer” and “person” for purposes of insurance holding companies and further providing for standards and management of an insurer within a holding company system. The bill also references HMOs and PPOs under the definition of insurer (Banking and Insurance)

HB 2500 (Hanna) - An act amending the Attendant Care Services Act further defining personal care attendant (Aging and Youth)

SB 1441 (Schwartz) - An act amending the Health Care Facilities Act providing for hospital staffing, for protection for health care facility employees who initiate certain actions related to health care facility care or services and violations (Public Health and Welfare)

SB 1397 (Wozniak) - An act declaring orders not to resuscitate to apply to the maker regardless of location (Public Health and Welfare)

HB 2411 (Saylor) - An act authorizing an employee to inspect certain personnel files of his employer; providing for medical records (Labor Relations)

HB 2313 (Vance) - An act providing for certain immunizations in long-term care facilities (Health and Human Services)

HB 2318 (Costa) - An act providing for the Medicaid Patient Protection Act, establishing a statutory framework for Medicaid managed care, providing for the duties and obligations of contractors and the rights of beneficiaries (Health and Human Services)

HB 2305 (DeLuca): Provides for reportable events in medical treatment and for powers and duties of the Department of Health (Health and Human Services)

HB 2306 (DeLuca): Requires physicians and health care workers to report incompetent, negligent, unethical and illegal practices among physicians; requires companies that insure physicians to report any malpractice suit or claim against a physician and grants immunity to physicians who adhere to the act (Professional Licensure)

HB 2307 (DeLuca): Amends the Health Care Facilities Act to reduce the time permitted for hospitals to report official actions against physicians and broadening the reporting procedures of hospitals and health care agencies (Professional Licensure)

HB 2235 (Fairchild) - An act establishing a bill of rights for individuals with mental retardation and conferring duties on the Department of Public Welfare (Health and Human Services)

SB 1282 (Rhoades) - Provides for the licensure of acupuncturists (Consumer Protection and Professional Licensure)

SB 1284 (Bell) - Amends Osteopathic Medical Practice Act and provides for respiratory care practitioner certificate and permits and continuing education (Consumer Protection and Professional Licensure)

HB 2209 (Vance) - An act allowing doctors with volunteer licenses to prescribe medication to family members (Health and Human Services)

SB 1273 (Greenleaf) - Creates the Nonprofit Associations Act, providing for nonprofit corporations (Judiciary)

HB 2170 (Orie) An act providing for the screening of patients for symptoms of child abuse and establishing the Child Abuse Health Care Response Program in the Department of Public Welfare and providing for child abuse medical advocacy projects (Health and Human Services)
CRNP Update

continued from page 1

State law allows a CRNP to diagnose and to prescribe medical, therapeutic, diagnostic or corrective measures. A CRNP may do so, however, only in “collaboration with and under the direction of” a licensed physician.

State law does not require a physician to be physically present in the office suite when a CRNP is evaluating and treating a patient. Although the physician is not physically present in the office suite when the CRNP is performing medical acts, the law nevertheless considers the CRNP to be “under the direction” of a physician if:
- the licensed physician is immediately available through direct communications or by radio, telephone or telecommunications;
- there is a predetermined plan for emergency services that the CRNP and the supervising physician have jointly developed; and
- the physician is available on a regularly scheduled basis for:
  a) referrals;
  b) review of the standards of medical practice incorporating consultation and chart review;
  c) establishing and updating standing orders and drug and other medical protocols within the practice setting;
  d) periodic up-dating in medical diagnosis and therapeutics; and
  e) co-signing records when necessary to document accountability by both parties.

As noted above, the MPA permits a physician to delegate the performance of a “medical service” to another health care practitioner (such as a CRNP), so long as the delegation conforms to law and regulation. If, however, the physician knows or has reason to know that such delegation is inconsistent with the standards of acceptable medical practice or that it is otherwise prohibited by statutes or regulations, the physician is not permitted to delegate these duties.

Although the current statutes and regulations governing CRNP activities do not expressly prohibit a CRNP from prescribing drugs independently, those same laws state that a CRNP may only prescribe medication “in collaboration with and under the direction of a licensed physician.” Further, the PNL only allows a registered nurse to administer drugs to a patient on the order of a licensed doctor of the healing arts. Thus, it may be inferred that a CRNP may not independently prescribe drugs or write a prescription for medical or therapeutic interventions.

State regulations also mandate that when a CRNP is involved in the act of medical diagnosis or in the act of prescribing medical, therapeutic or corrective measures, the practice must establish a committee of CRNPs and physicians to establish standard written policies and procedures which set forth the “scope and circumstances” of the CRNP’s medical management of patients. The committee must “review and accept” the policies and procedures at least annually (and at such other times as is necessary), and must review the effectiveness of the “medical functions” of the CRNP by evaluating patient care. The committee may use patient records, statistics and patient follow-up to conduct such an evaluation.

Liability

A CRNP is responsible for his or her own professional judgments and is accountable to the patient, the physician, and his or her employing agency. Therefore, if a CRNP compromised patient care as a result of his or her actions, (s)he would presumably have independent liability exposure as to that patient.

A supervising physician may be liable for the negligent acts of a CRNP he or she is supervising under the common law theory of respondeat superior, if any patients were to suffer harm. Such negligence can arise from inadequate supervision and improper delegation. Respondeat superior requires that there be an agency relationship between the person acting in a negligent fashion and the person sought to be held responsible. For there to be an agency relationship, there needs to be a manifestation by the principal that the agent was acting for the principal, an acceptance of the undertaking by the agent, and an understanding by the parties that the principal is in control of the undertaking. Statutory language of the MPA establishes physician responsibility for duties he or she has delegated to the CRNP.

The theory of corporate liability has been expanded in Pennsylvania beyond hospitals. The Superior Court assigned two of these duties, specifically duties 2 and 4 above, to IPA model HMOs. Additionally, at the Common Pleas Court level in Pennsylvania, corporate negligence has been assigned to professional corporations employing physicians. Thus, if a patient were to have suffered harm, the Practice could be vicariously liable for the acts or omissions of the physicians and the CRNP. In addition, it could be directly liable under a negligent credentialing or negligent hiring theory.

Changing State Law

In 1999, Rep. Patricia Vance introduced HB 50. This bill would have eliminated dual control by the State Board of Medicine and State Board of Nursing, and it would allow for sole governance by the Board of Nursing. Further, it would have granted prescriptive authority to CRNPs.

After much debate over this legislation, the Medical and Nursing Boards reached an agreement, but this agreement, which would have required a 45-hour advanced pharmacy course and a 2:1 physician to CRNP ratio, was initially not approved by the Independent Regulatory Review Commission (IRRC).

The CRNP regulations that were rewritten to address concerns expressed by the IRRC, and in September 2000, the Boards agreed to approve the revised regulations. The revisions changed the earlier requirement of a 45-hour advanced pharmacy course to that of an accumulated 45 hours of advanced pharmacy education. Further, the 2:1 ratio of physicians to CRNPs was increased to 4:1. There is no limit on the number of CRNPs that a physician may collaborate with, so long as (s)he was collaborating with no more

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than four CRNPs at one time. The new regulations will allow CRNPs to prescribe and dispense certain categories of drugs relevant to their area of practice pursuant to collaborative agreements with physicians.

There was no opposition to the revised regulations during a public hearing in October. The IRRC then voted to approve the regulations on its second review. The regulations will be published in the Pennsylvania Bulletin (in November, at the earliest), at which time they will go into effect.

6 63 P. S. § 422.17.
7 63 P. S. § 422.15.
3 63 P. S. § 422.15.
4 49 Pa. Code §§ 18.21, 21.251
5 CRNPs act as physician extenders, in a manner similar to physician assistants. Under the Physician Assistant (PA) regulations (which are more explicit than those regulating CRNPs), a physician must see each hospitalized patient at least once and must see office patients once every third visit. A PA must report medical regimens executed or relayed by him/her, while the supervisor was not physically present, to the supervisor within 12 hours. The PA must record, date and authenticate the medical regimen on the medical record at the time the regimen is executed or relayed, and the supervising physician must countersign the medical record within 3 days (or sooner if required by other regulations or contractually). The PA must report to the supervisor, when the supervisor was not physically present at the time of prescribing/dispensing, any drug prescribed or medication dispensed by the PA, and the PA must record pertinent information regarding the prescription in the patient's chart at the time of prescribing/dispensing. 49 Pa. Code §§ 18.144, 18.153, 18.158. Because the law arguably gives PAs broader latitude than CRNPs to treat patients independently, it is likely that medical practices must at minimum meet the oversight requirements of the PA regulations when supervising CRNPs.

7 "Medical service" is an activity which lies within the scope of the practice of medicine and surgery. 63 P. S. § 422.2.
8 63 P. S. § 422.17.
14 Id.
16 See Karas v. Jackson, 582 F.Supp.43 (E.D. Pa. 1983)(doctor who set policies but who was not "in charge" was not responsible for death of patient during amniocentesis performed by another practitioner).
17 63 P. S. § 422.17(c).
19 The leading case establishing corporate negligence is Darling v. Charleston Community Memorial Hospital, 211 N.E. 2d 253 (Ill. 1965). The duty to select and retain competent physicians was noted in Purcell v. Zimbelman, 500 P.2d 335 (Ariz. App. 1972) and in Thompson v. Nason Hospital, 591 A.2d 703 (Pa. 1991).
New State Self-Disclosure Program
by Jeff Bechtel, Bureau of Program Integrity Director

The Department of Public Welfare’s Bureau of Program Integrity (BPI) recently released a draft Pennsylvania Medical Assistance Voluntary Disclosure Protocol for public review and comment. The department received several comments from individual law firms and professional associations prior to the conclusion of the comment period on Oct. 30, and is presently reviewing these comments to determine whether they should be incorporated into the final protocol. It is anticipated that a final protocol will be issued by the end of the year. The protocol will likely be sent to all providers as a Medical Assistance (MA) Bulletin, and will be posted on the Office of Medical Assistance Program Web site www.dpw.state.pa.us/omap/.

Although voluntary self-disclosures have always been encouraged, DPW has never reduced its policy to writing. The purpose of this policy is to memorialize and disseminate DPW’s policy, and to encourage medical assistance providers to voluntarily review their billing practices and subsequently return any overpayments to the department. In order to provide a tangible benefit to providers that self-disclose, the policy advises providers that they can return overpayments without penalty to the extent that such overpayments were not the result of criminal conduct.

Although the protocol has not been finalized, it is likely to provide two methods to return overpayments that cannot be easily quantified. The first will be through the utilization of a statistically valid sampling protocol that will be described into the final protocol. The department will likely accept this methodology without severe scrutiny. The second method will be more flexible. In essence, BPI representatives will agree to meet with providers that wish to self-disclose prior to the initiation of a self-audit, and will attempt to reach a mutually agreeable audit methodology.

The department believes that this policy will benefit all involved. Providers will benefit because they will be provided a mechanism to avoid the imposition of penalties. The department will benefit because it will be permitted to better utilize its resources to review self-audits, rather than conduct its own comprehensive reviews. Finally, and most importantly, the public will benefit, as the protocol will help protect the financial integrity of the Medical Assistance Program.

Federal Self-Disclosure

In recent articles in the ABA’s Health Lawyer the federal Inspector General’s Self-Disclosure Program was analyzed. Following are excerpts from that article.

Perhaps one of the most difficult decisions for a health care provider’s compliance officer is whether to inform law enforcement about suspicious transactions that resulted in overcharges to the government. It is a felony for a health care provider to “fail to disclose information with the fraudulent intent to secure an overpayment.” 42 U.S.C. §1320a-72(a)(3). For this and many other reasons, overcharges should be repaid and/or reported to some entity within the government. However, a provider must decide whether to simply address the matter with the affected regulatory agency or agencies, or take the more significant step of disclosing the matter to a representative of law enforcement, such as the Office of Inspector General of the Department of Health & Human Service, a U.S. Attorney’s Office, or the Federal Bureau of Investigation.

The Department of Health and Human Services Office of Inspector General (OIG) has adopted a protocol for voluntary disclosures that may be used by all health care providers, regardless of medical specialty, or corporate form. Pursuant to OIG’s Self Disclosure Protocol, a provider may report matters “that in the provider’s reasonable assessment, are potentially violative of federal criminal, civil or administrative laws.” OIG asks that such matters be reported “only after an initial assessment substantiates there is a problem with non-compliance program requirements.” OIG imposes no time limit on when such matters may be reported, and will even allow providers already under investigation to utilize the protocol in lieu of an OIG-initiated investigation.

OIG excludes two types of transactions from its Self-Disclosure Protocol: (i) those involving ongoing fraud (such matters should be reported immediately to OIG without following the Protocol’s recommended steps for investigating and quantifying the problem), and (ii) those “exclusively involving overpayments or errors that do not suggest that violations of law have occurred” (the latter should be reported to the federal entity that processed the claims). To make a self-disclosure to OIG, a provider must conduct an internal investigation of the conduct, and render a “financial assessment” of the amount of government funds at issue, in conformity with detailed guidelines set forth by OIG. The provider must submit a certified, written report on its findings to OIG, with all underlying information - such as audit reports and notes of employee interviews- being made available for OIG’s review and verification. OIG’s protocol contains guidance on how to use statistically valid sampling to estimate the financial impact of the disclosed matter.

Upon receipt of the provider’s report, OIG conducts a “verification of the factual information in the report. Following this verification, OIG works with the provider to resolve the matter.

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2001 Excellence in Health Care Law Award
Nominations Now Open

Nominations are being accepted for the 2001 Excellence in Health Care Law Award. Nominees should demonstrate the best of our profession. Please send nominations by Dec. 31 to:

Thomas Blazusiak, Chair
Health Care Law Committee
Pennsylvania Bar Association
P.O. Box 186
Harrisburg, PA 17108
Fax (717) 238-7182
**National Briefs**

**ADA**

The court in *Lenker v. Methodist Hospital* 210 F.3d 792 (7th Cir. 2000) held that the ADA was not violated by the firing of a nurse who could not lift 200 pounds because the duty was a necessary part of the job and the hospital accommodated the nurse by reasonable means.

**Whistleblowers**

Private persons may sue under the qui tam provisions of the False Claims Act where the government declines to prosecute. *Vermont Agency on Natural Resources v. U.S. ex Rel Stevens*, No. 98-1818 (U.S. May 2000)

**Peer Review**

Montana Supreme Court holds incident report may be discovered in *Huether v. District Court*, No. 99-032 (Mont. June 20, 2000)

Texas appeals court holds incident reports are protected in *Re Osteopathic Med. Ctr.*, 16 S.W. 3d 881 (Tex Ct. App. 2000)

**No Duty for Stolen Drugs**


**ERISA Claim Denied**

The U.S. Supreme Court held there was no violation of ERISA for medical judgement denial and care program. *Pegram v. Hedrich*, No. 98-1949 (U.S. June 12, 2000)

**HIPAA Final Rule on Electronic Transactions Issued**

HCFA published on Aug. 17, 2000 a final rule on electronic transactions at 63 Fed. Reg. 50312. The rule requires providers to use standard practices and is intended to promote efficiency and uniformity. It intends to eliminate local practices and expects providers to eliminate all local codes nine standard transactions that must be used. They are:

1. Health care claims or equivalent encounter information;
2. Health claims attachments;
3. Health plan enrollments and disenrollments;
4. Health plan eligibility;
5. Health care payment and remittance advice;
6. Health plan premium payments;
7. First report of injury; and
8. Health care claim status.

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**State Briefs**

**Workers Comp Denied**

**Psychological Injuries**

In order to recover for psychological injuries a claimant must show more than subjective reaction to normal working conditions. *Rodgers v. PSP*, No. 153CD 1999 (Sept. 13, 2000)

**Reurrence**

In *Valentin v. PSP* the court held that recurrence of injury not originally compensable under the Workmens Compensation law is not subsequently compensable. 66 CD 1999 (Aug. 31, 2000)

**EMTALA**

Summary judgement denied where factual issues remained in a pre-screening denial case where issues of insurance coverage and withdrawal of request were outstanding. *Potami v. Frankel*, 120 Dauphin 11 (June 16, 2000).

**Medicare and Medicaid Settlements**

*Bayer* agreed to settle medicaid cheating allegations with the state and federal government for $14 million. The government alleged that the provider established a plan to set extremely high average prices for hemophiliac medication and then providing deep discounts to doctors.

*Quorum Health Corporation* agreed to pay almost $100 million to settle with medicare. The medicare case began as a qui tam case.

**Excellence in Health Care Law Award**

The Health Care Law Committee is proud to announce that it presented its Annual Award for Excellence in Health Care Law to Roland Morris. The award was presented at the recent Hot Topics in Health Law Conference.

Known to most people as “Rollie,” this year’s award recipient has been involved in a variety of areas of health law practice. He is known not only for his expertise and professionalism but for his good sense of humor and ability to work through problems. Congratulations to Rollie for a well earned honor.

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**WANTED:**

**Subcommittee Chairs**

The Health Care Law Committee is seeking a few good members to help with committee chair duties. These include chair of the Annual Meeting Program Subcommittee, the Legislative Subcommittee, the Lunch and Learn Subcommittee in Pittsburgh, the Lunch and Learn Subcommittee in Harrisburg, and the Lunch and Learn Subcommittee in Philadelphia.

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**Authors Wanted**

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 Rob Quigley at (717) 237-5549
Seclusion and restraint are the issues of greatest concern to hospitals in the new guidelines which clarify the medicare conditions of participation. Surveyors will be using these guidelines. Restraints are based upon the intent of the use so if a device or drug serves multiple purposes such as a gerichair it could constitute a restraint if the effect is to restrict movement rather than to help position the patient. Documentation will be critical in determining the intent of the device or drug. See www.hcfa.gov/quality/4b2.htm.

The DHHS OIG published in the Oct. 5 Federal Register (65 Fed. Reg. 59434) its Compliance Program Guidance for Individual and Small Group Physician Practices. The guide addressed four areas of concern for physicians:

a. Kickbacks, self referrals and related direct or indirect inducements.

b. Rules relating to documentation for services.

c. Definition of reasonable and necessary.

d. Billing practices including proper coding.

Don’t forget the PBA Health Care Law Committee Meeting Nov. 30!
See page 5 for details.