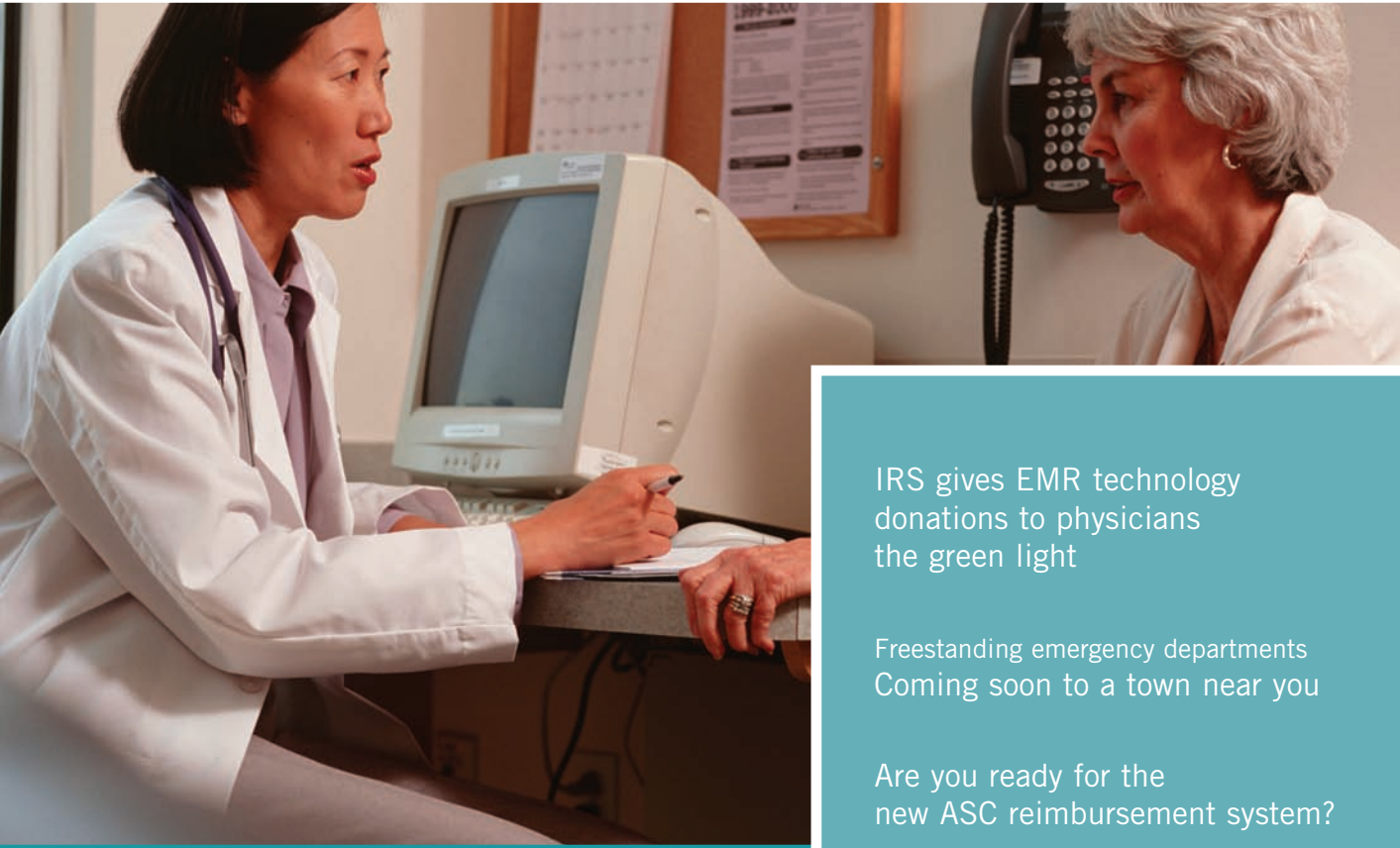


PRACTICAL HEALTHLAW



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IRS gives EMR technology donations to physicians the green light

After an industrywide push for guidance, the IRS has published a memorandum expressly granting nonprofit hospitals the ability to provide electronic medical record (EMR) technology to physicians. If the decision is made by the hospital to donate EMR technology, the IRS requires that it be available to all physicians on the hospital's medical staff. This IRS memorandum has many implications — both legal and strategic.

HIPAA PRIVACY CONCERNS

In its memo, the IRS detailed steps nonprofit hospitals must follow when providing EMR technology to physicians. Of particular concern to some privacy advocates is the requirement that the hospital and each physician or physician group enter into health information technology subsidy agreements that allow the hospital to access all of

the EMRs created by a physician using the health information technology subsidized by the hospital.

Privacy advocates contend that because hospitals will have access to all physician-patient records — including those records of patients who aren't hospital patients — it will lead to data mining of physician records. Some physicians also fear it has the potential to violate physician-patient confidentiality.

But health care providers are divided as to whether the IRS memorandum allows such open access to patient records. The IRS explicitly permits the sharing of patient records only “to the extent permitted by law.” This seems to indicate that the IRS believes HIPAA is sufficient to maintain patient privacy.

Others believe that, even though a health information technology subsidy agreement may protect patients' privacy, HIPAA limitations aren't broad enough to protect the patient information to which hospitals would have access based on the IRS memorandum.

Because of the uncertainty created by the IRS memorandum, physicians should seek legal counsel when drafting or signing subsidy agreements to ensure that all subsidy agreements contain appropriate language to protect the confidentiality of patient medical records.

SHARED MEDICAL RECORDS BENEFITS

Despite patient privacy issues, the IRS-required subsidy agreements allow for a free exchange of information which can benefit the patient. Subsidy agreements that allow hospitals access to all physician-patient records would give hospitals quicker access to the patient's treatment history and current medications.

This could help prevent the occurrence of adverse events and medical errors during treatment. It would also help the hospital develop a treatment plan that



is consistent with the patient's previous treatments. In fact, for some patients any privacy risks may be outweighed by the higher quality of care the free exchange of information might provide.

EQUAL ACCESS

Because the IRS specified that the EMR technology a nonprofit hospital provides must be available to all physicians on the hospital's medical staff, a hospital may not selectively provide the technology only to physicians that bring in the most revenue. This is in line with the Stark Law exception and the Anti-kickback Safe Harbor for Electronic Health Record Arrangements.

But the IRS memorandum does allow hospitals the right to vary the subsidy amount given to medical staff physicians by applying criteria related to meeting the health care needs of the community served by the hospital.

However, the IRS fails to elaborate on what these criteria might include, instead allowing hospitals to set the criteria themselves. Thus it's possible that a hospital could create criteria that apply to only those specialties that are larger revenue sources for the hospital and exclude other specialties. Health care providers will need to watch to see how the IRS deals with this issue in the future.



EMR benefits and limitations

The ultimate goal of electronic medical record (EMR) technology is to set up a network that allows health care workers to access information. This network may be small, linking a few offices, or it may be much larger, linking an entire system of hospitals. EMR technologies facilitate the transfer of information — within the limits of applicable privacy laws.

EMR systems can provide:

- Clinical documentation,
- Prescription writing,
- Interoffice messaging,
- Laboratory interface (allowing for direct downloading of lab results),
- Real-time coding assistance,
- Data links to other devices (such as EKG machines),
- Clinical decision support (such as medication interaction alerts and practice reports), and
- Voice recognition dictation.

Keep in mind that not all EMR systems are completely paperless. Some allow you to scan documents into the system, creating a more complete medical record. You still may need to print paper copies of documents. For example, a patient may receive care from a practice or hospital that either doesn't have an EMR system or has one that isn't compatible with yours.

WHAT NEXT

Now that the IRS has released EMR technology guidance, here's what nonprofit hospitals and physicians can do:

Nonprofit hospitals. Begin preliminary investigations into the provision of EMR technology. Determine the benefits of providing the EMR technology and whether the expenditures will benefit the hospital. Be aware of the possible concerns that physicians may have in accepting such technology and address those issues early in the process.

Physicians. Examine your individual practice situation and determine whether EMR technology will be beneficial to your individual practice or group. Be aware of the privacy concerns and seek legal counsel to help your practice develop a subsidy agreement that provides adequate privacy protections.

PROCEED WITH CAUTION

The initial excitement about the IRS memorandum has begun to wear off, as many have taken a detailed look at the requirements for nonprofit hospitals providing EMR technology to physicians. Both hospitals and physicians should proceed cautiously. ■

Coming soon to a town near you

Freestanding emergency departments (EDs) are becoming more prevalent. Like hospital-based EDs, freestanding facilities can offer a wide range of services and provide emergency services with or without hospital affiliation. The legal and reimbursement issues change depending on the type of facility. This article will focus on freestanding EDs that are affiliated with a hospital but physically independent.

WHY THE POPULARITY?

Here are a few reasons the number of freestanding EDs is growing:

Less expensive than building a new hospital. In an era of lower reimbursement rates, hospitals are looking to increase their patient base and enter new markets. Freestanding EDs allow hospitals to achieve these goals without the expense of building an entire hospital.

Patient convenience. Freestanding EDs can take the pressure off of a hospital's main ED, as parent hospitals can locate them closer to residential neighborhoods, giving potential patients a second, more convenient option for care. They also offer increased exposure for hospitals in suburbs where new growth is taking place.

Shared resources. Most freestanding EDs are located within 15 miles of the parent hospital, so freestanding ED physicians can send patients to the main hospital facility when more expensive equipment is required. The ability to share resources and reach additional patient populations can lead to higher hospital revenues.

WHAT ABOUT MEDICARE'S CoP?

On its face, Medicare's Conditions of Participation (CoP) for emergency departments don't specifically address the



operation requirements for freestanding EDs. The regulation requires only that a hospital:

- Meet the emergency needs of patients in accordance with the standards of practice,
- Organize and direct the emergency services under a qualified member of the medical staff, and
- Integrate services with other hospital departments.

The CoP's *State Operations Manual Interpretive Guidelines* provide more detail. The guidelines require that a freestanding ED integrate with other hospital departments, including surgery, laboratory services, the intensive care unit and diagnostic services.

At a minimum, emergency services integration includes:

- Coordination and communication between the freestanding ER and other hospital services or departments,
- Physical access for freestanding ER patients to the services, equipment, personnel and resources of other hospital departments,

- The immediate availability of services, equipment, personnel and resources of other hospital departments or services to emergency patients to assess and render appropriate care for an emergency patient, and
- The availability of services, equipment, personnel and resources of other hospital departments to freestanding ED patients within timeframes that protect the health and safety of patients and within acceptable standards of practice.



WHAT ABOUT PROVIDER-BASED REGULATIONS?

Hospitals have the option to have their off-site facilities classified as a provider-based department for reimbursement purposes. If the hospital chooses this option, the facility must then comply with the Medicare provider-based regulations governing off-campus facilities affiliated with a main hospital campus. The regulations vary depending on the type and location of the off-site ED. The provider-based regulations require:

Licensure. If required by the state licensing requirements, the freestanding ED will fall under the parent hospital's license as an off-site location. In such a case, the freestand-

ing facility must comply with applicable licensure rules. Some states, however, don't extend the licensing requirements to off-site outpatient departments of hospitals. Be sure to check your state licensing requirements.

Clinical integration. The facility must be integrated with the main hospital's clinical services. Medicare requires the following:

- Medical staff working at the freestanding ED must have clinical privileges at the main hospital.
- The main hospital must monitor and oversee the freestanding ED as it does with individual departments located within the hospital.
- The freestanding ED's medical director must have the same reporting relationship with the hospital's Chief Medical Officer as exists for other hospital medical directors.
- The medical staff committee at the hospital must be responsible for services provided at the freestanding ED.

- The freestanding ED must integrate its patient medical records into a unified system with the hospital's medical records.
- Patients that have been treated at the freestanding ED must have full access to all hospital services.

Financial integration. Medicare requires a freestanding ED to share income and expenses with the main hospital. The hospital must report the freestanding ED's expenses on its cost report. And it must bill for all services provided to the freestanding ED and report all expenses associated with the provision of those services.

Public awareness. Publicly, the freestanding ED must be held out as a part of the hospital. When patients enter the freestanding ED, they must know that they will be billed by the hospital.

Ownership and control. The hospital must operate the freestanding ED. The hospital's organizational documents (such as its bylaws) and governing body must govern the freestanding ED.

Administration and supervision. The relationship between the freestanding ED and the hospital must have the same frequency, intensity and level of accountability that exists between the hospital and its other departments.

HOW DOES EMTALA AFFECT FREESTANDING EDs?

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals that receive Medicare payments to provide emergency care to individuals in need of such care regardless of citizenship, legal status or ability to pay. Freestanding EDs are considered a department of the hospital. Therefore they must comply with EMTALA requirements.

EMTALA requires that EDs provide a medical screening examination, performed by a qualified medical person, to determine whether the patient has an emergency condition. If it's determined that the patient has an emergency condition, the medical personnel at the freestanding ED must either stabilize the patient or provide for an appropriate transfer to another facility. Under EMTALA, freestanding EDs must also maintain an on-call schedule.

IS IT THE RIGHT CHOICE?

Freestanding EDs have become an alternative for many hospitals looking to expand their patient base. When considering whether such a facility is the right choice, remember that a freestanding ED is treated as another hospital department. As such, it must comply with the same rules and regulations applicable to the main hospital. Also, examine your state hospital licensing regulations applicable to the development of a freestanding ED. ■

Are you ready for the new ASC reimbursement system?

CMS has released the final rule revising the payment system for ambulatory surgical centers (ASCs), and it applies to all services provided after Jan. 1, 2008. The Medicare Modernization Act of 2003 called for the new system, and the Deficit Reduction Act of 2005 imposed additional requirements.



Under the final rule, all procedures performed in an ASC are now covered and classified using ambulatory patient classifications (APCs). Under this new classification system, the ASC cannot be reimbursed at a rate greater than the OPSS (outpatient prospective payment system) rate. CMS will separately reimburse ASC facilities for ancillary services that are integral to the covered surgical procedure. There are several other changes as well.

EXCLUSION VS. INCLUSION

The previous system used a list of approved procedures, combined with a requirement that the procedures take no longer than 90 minutes, plus four hours of recovery time, and generally don't require an overnight stay. The CMS "inclusive" list contained over 2,500 covered procedures.

This has now been replaced with an exclusion methodology that eliminates the list of "approved" procedures. Instead of limiting payment to an ASC facility based on a CMS-specified list of procedures, payment is now allowed for any surgical procedure — except those that CMS explicitly excludes from payment. CMS will exclude procedures that it deems not safe when provided in an ASC or that require an overnight stay.

This change will give physicians the ability to provide a greater number of procedures in an ASC than previously allowed under the "approved procedures" listing methodology. Proper coding will be important because of additional covered procedures.

REIMBURSEMENT RATES LOWERED

CMS has also lowered its reimbursement rates. CMS calculates rates by assigning weights to each procedure and then multiplying these weights by a conversion factor. Procedures that require more resources are assigned higher weights, and procedures that require fewer resources are assigned lower weights.

Under the new payment system, ASC payment weights will be set equal to the OPSS payment weights for hospital outpatient procedures.

Although the payment weights are equal to hospital outpatient procedures, the reimbursement rates deviate when the conversion factors are added into the calculation. ASC conversion factors are less than those for outpatient procedures performed at a hospital because of the lower overhead costs of operating an ASC.

The 2008 conversion factor is 62% of the estimated 2008 OPPS conversion factor.

2011 rates: 100% of the revised 2011 HOPD.

PHASED TRANSITION TO THE NEW PAYMENT SYSTEM

CMS will phase in the new system, giving ASCs the opportunity to adjust to the new rates. ASC payments will be made up of a combination of ASC rates and hospital outpatient department (HOPD) rates. Here is a breakdown of how CMS will roll out the new rates:

2008 rates: 75% of the 2007 ASC rate and 25% of the revised 2008 HOPD rate.

2009 rates: 50% of the 2007 ASC rate and 50% of the revised 2009 HOPD rate.

2010 rates: 25% of the 2007 ASC rate and 75% of the revised 2010 HOPD rate.

Under the new payment system, ASC payment weights will be set equal to the OPPS payment weights for hospital outpatient procedures.

PLANNING IS CRITICAL

ASC facilities now have the information they need to plan for the upcoming changes and should begin making adjustments. In addition, facilities will need to stay up to date as CMS publishes new rates to determine what effect this will have on the individual facility. ■

THE 2008 OIG WORK PLAN

Each year, the Office of Inspector General (OIG) identifies a comprehensive work plan for the following year that outlines areas of focus. The following are some of the issues the OIG plans to address in 2008:

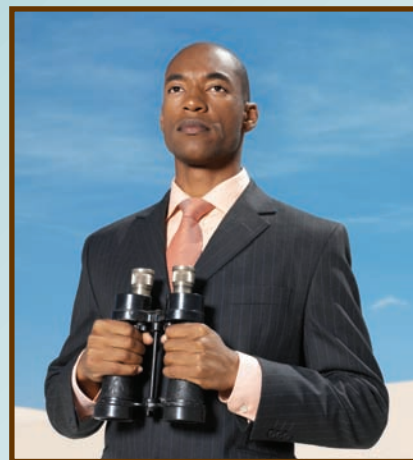
Hospital and provider bad debt. OIG will review Medicare bad debts claimed by some facilities to determine whether they can be reimbursed under facility cost-reporting programs. Hospitals and skilled nursing facilities can claim uncollectible debts related to beneficiary copayments and deductibles as Medicare bad debt if they meet specific criteria. The OIG also will look to determine if recoveries for prior year write-offs were made in accordance with regulations.

Inpatient prospective payment system (IPPS) wage index. CMS uses hospital wage data to calculate the wage index used for the Medicare IPPS. To calculate the wage index, hospitals must accurately report wage data. OIG will determine whether hospitals have properly reported wage data and the effect improper wage data has on reimbursement rates. It also will review hospital and Medicare controls over the accuracy of hospital reported wage data.

MRIs and business relationships. OIG will be looking at the business relationships between physicians, billing providers and others who work together to provide imaging services to determine if the relationship affects the use of services. In particular, it will review the parties' financial relationships to identify whether they're associated with high use.

Patient care and safety in physician-owned specialty hospitals. OIG will review patient care and safety in physician-owned specialty hospitals to ensure compliance with Medicare Hospital Conditions for Participation. As the number of these hospitals has increased, Congress and CMS have become more involved with the quality of care provided at such facilities. OIG review will include an examination of facility policies regarding staffing requirements at physician-owned specialty hospitals.

This is only a small sampling of OIG's 2008 agenda. A full listing can be found in OIG's published report found on the Internet at <http://oig.hhs.gov/publications/workplan.html>. Review the full publication with your legal counsel to assess if any of the topics pertain to your practice or organization.



A message to our clients and friends:

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IN Downtown Office:	Suite 2000, Box 82064, One American Square, Indianapolis, IN 46282, Ph: 317-633-4884 Fax: 317-633-4878
IN North Office:	Suite 820, 8402 Harcourt Road, Indianapolis, IN 46260 Ph: 317-871-6222 Fax: 317-338-3946
KY Office:	614 West Main Street, Suite 4000, Louisville, KY 40202 Ph: 502-568-1890 Fax: 502-568-4878
MI Lansing Office:	110 West Michigan Avenue, 12th Floor, Lansing, MI 48933 Ph: 517-703-8632 Fax: 517-487-8623
MI Troy Office:	Columbia Center, Suite 315, 201 W. Big Beaver Road, Troy, MI 48084 Ph: 248-740-7505 Fax: 248-740-7501
WI Office:	111 East Kilbourn Avenue, Suite 1300, Milwaukee, WI 53202 Ph: 414-721-0442 Fax: 414-721-0491