PART B DRUGS REMOVED FROM PAYMENT FORMULA UNDER PROPOSED PHYSICIAN FEE SCHEDULE RULE

The proposed rule, released as a display copy on July 1, 2009, offers several policy changes and payment rate revisions that will affect approximately one million practitioners paid under the Medicare Physician Fee Schedule (PFS). The Centers for Medicare and Medicaid Services (CMS) estimates a 21.5 percent rate reduction in physician payments for 2010 unless Congress intervenes, as it traditionally has, to mitigate the effects of the Sustainable Growth Rate update formula. Increases are, however, proposed for primary care services furnished by general practitioners, family physicians, internists and geriatric specialists. The proposed rule contains a 2010 conversion factor of $28.3208, reduced from $36.0666.

In a move hailed by the American Medical Association, CMS proposes to remove office-administered Part B drugs from the 2010 PFS calculation by eliminating such drugs from the definition of "physician services." This revision is made in anticipation of fundamental Medicare reform legislation, and CMS does not foresee that the proposal will change the projected update for services during 2010; however, the agency forecasts that it would "reduce the number of years in which physicians are projected to experience a negative update."

Furthermore, CMS proposes to "budget neutrally" eliminate the use of all consultation codes by increasing the work relative value units (RVUs) for new and established office visits, initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into practice expense and malpractice RVU calculations. In its press release, CMS states that the "resulting savings would be redistributed to increase payments for the existing E/M services."

The proposed rule contains two changes to address growth in high-cost imaging services. CMS proposes to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million and to reduce payment for services that require the use of expensive imaging services. Additionally, the proposal addresses the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirement that suppliers of the technical component of imaging services be accredited through accrediting organizations beginning January 1, 2012. The accreditation requirements would not apply to the physician who interprets the images, but to the facilities that create the images, including mobile units, physician’s offices and independent diagnostic testing facilities.

The proposed rule also adds more measures and more measure groups for eligible professionals to report under the Physician Quality Reporting Initiative (PQRI), provides a process for group practices to report quality measures and presents a mechanism for submitting quality measure data from a qualified electronic health record. CMS has released a Fact Sheet summarizing the proposed rule changes to the PQRI.

The proposed rule is slated for publication in the Federal Register on July 13, 2009. Comments must be received by August 31, 2009. For more information, please contact Donna S. Clark, dclark@bakerlaw.com or 713.646.1302, or Ameena N. Ashfaq, aashfaq@bakerlaw.com or 713.646.1329.
NAVIGATING THE REVISED TJC INITIAL ACCREDITATION SURVEY PROCESS: EARLY SURVEY OPTION NO LONGER THE EARLIEST OPTION?

The 2008 elimination of the four-month "track record" for initial accreditation surveys has created some questions regarding the best way to approach the initial accreditation process for hospitals. Historically, The Joint Commission (TJC) required that each new hospital demonstrate a four-month "track record" of compliance in order to be eligible for a full initial accreditation survey. For hospitals relying on TJC accreditation for CMS-deemed status purposes, four months represents a significant stall in the Medicare certification process.

To speed things up, TJC previously provided two "early survey" policy options, both of which required hospitals to undergo two initial surveys. Under "Early Survey Policy Option 1," the first survey, which was a partial survey, could be conducted up to two months prior to opening with the result being "preliminary accreditation" status for the hospital, a designation not recognized by CMS for deemed status purposes. A second survey was conducted four months later, and if successful, the hospital was awarded full accredited status at that time.

The first survey under "Early Survey Policy Option 2," was not conducted until the hospital had been in operation at least one month, treated a minimum of ten patients and had at least one patient in active treatment at the time of survey. Because the first survey under Option 2 was a full initial survey, a successful hospital could receive full accredited status recognized by CMS for deemed status purposes at that time. A follow-up survey was conducted four months later, at which time TJC would confirm the hospital's track record and standards compliance.

Two significant revisions were made during 2008 to the initial survey process outlined in TJC's Comprehensive Accreditation Manual for Hospitals. First, TJC eliminated the track record requirement, such that a new hospital is now eligible for a full initial accreditation survey as soon as it has treated a minimum of ten patients, with one patient in active treatment at the time the survey is conducted. The eligibility determination is made only with regard to the minimum patient requirement and no longer is dependent upon the amount of time the hospital has been in operation. The second significant revision eliminated Early Survey Policy Option 2. Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2009).

Because Early Survey Policy Option 1 remains in the Manual, if read together with the elimination of the track record requirement, the result is surprising. If a hospital chooses the remaining Early Survey Policy Option, it would assume that full accreditation is not available until four months following the first survey. However, if the hospital forgoes the Early Survey Policy altogether, a full initial accreditation survey now is possible as soon as the minimum number of patients is reached.

New hospitals should be able to work with TJC to obtain a full accreditation survey when the patient threshold is met, even if the Early Survey Policy is chosen. While not required, obtaining a preliminary survey prior to opening, pursuant to the Early Survey Policy, may assist the hospital in identifying and addressing any facility issues prior to the full accreditation survey.

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OHIO SUPREME COURT HOLDS THIRD PARTY MEDICAL RECORDS ARE NOT DISCOVERABLE IN A PRIVATE CIVIL ACTION

On July 1, 2009, the Ohio Supreme Court held that unrelated third party medical records are not discoverable in a private civil action, even if all personally identifiable information has been redacted. Roe v. Planned Parenthood Southwest Ohio Region, No. 2009-Ohio-2973, slip op. at 2 (Ohio 2009). Plaintiffs filed an action against Planned Parenthood Southwest Ohio Region and others alleging that Planned Parenthood illegally performed an abortion on the Plaintiffs' fourteen-year-old daughter. At issue before the Ohio Supreme Court was the Plaintiffs' attempt to discover from Planned Parenthood medical records of nonparty minors who had been patients at Planned Parenthood during a ten-
year period. The court held that such records are not discoverable; the medical record privilege holds, even if all personally identifiable information has been redacted from the records. In so holding, the court rejected Plaintiffs’ argument that Biddle v. Warren General Hospital, a case decided by the court in 2008, provides a right of discovery when the “disclosure is necessary to protect or further a countervailing interest that outweighs the patient’s interest in confidentiality” (quoting Biddle v. Warren Gen. Hosp., 715 N.E.2d 518 (Ohio 2008)). The Biddle balancing test, the court held, applies only to determine liability of the releasing party when there already has been an unauthorized release of medical records, “i.e. the circumstances under which a physician or hospital may release confidential medical records in the absence of a waiver without incurring tort liability.” In contrast to a number of prior Ohio appellate court cases, the Ohio Supreme Court’s decision in Roe means that, while the Biddle balancing test may be used after an unauthorized disclosure to limit liability for such disclosure, it may not be used to actually compel or authorize the disclosure. The Roe court went on to state that redaction of personally identifiable information from medical records does not defeat the records’ privileged nature, reasoning “[r]edaction is merely a tool that a court may use to safeguard the personal, identifying information within confidential records that have become subject to disclosure either by waiver or by an exception.”

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TOO TIRED TO DRIVE HOME? TEXAS SUPREME COURT SAYS DON’T WORRY

In a recent decision, the Texas Supreme Court held that employers generally owe no duty to third parties for off-duty accidents caused by employees who leave work in an extremely fatigued state. Nabors Drilling, U.S.A., Inc. v. Francisca Escoto, No. 06-0890 (Tex. 2009). Texas employers also have no duty to train employees about the dangers of fatigue.

However, good deeds may not go unpunished. An employer may have responsibility if the employer had actual knowledge that its employee was impaired when leaving work and affirmatively exercised control over the employee incapacitated by fatigue (e.g., sending the employee home early for fatigue). Merely requiring an employee to work to the point of fatigue will not impose liability on an employer.

The court concluded that “considering the large number of Texans who do shift work and work long hours (including doctors, nurses, lawyers, police officers and others), there is little social or economic utility in requiring every employer to somehow prevent employee fatigue or take responsibility for the actions of off-duty, fatigued employees.” However, the court left open the possibility for liability if fatigue incapacity is the inevitable result of employer-established work conditions.

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HOSPITALIST TRENDS

A common trend among hospitals today appears to be the hiring of hospitalists rather than primary care physicians or specialists (PCP) for patient care. According to the Society of Hospital Medicine, 40 percent of hospitals in the United States employ hospitalists. One reason hospitalists are in demand is that they are able to provide around-the-clock care in the facility, whereas PCPs spend more time with patients in an office setting. Also, with the reduction of hours a resident can work, many hospitals have employed hospitalists to help assure that continuity of care is not disrupted. Many insurance companies also are endorsing the use of hospitalists. Some insurers require their PCPs to transfer the care of their hospitalized patients to hospitalists. However, because of the backlash from PCPs, regarding mandatory care transfer programs, some insurance companies have instituted different voluntary transfer of care program models. In other cases, some physician group practices have created their own hospitalist programs.

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