

# The RAP Sheet

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—from a declaration of the American Bar Association

## Medicare Bad Debt Litigation: Plenty of Activity, Few Clear Answers for Providers

*Jon P. Neustadter, Esquire  
Jordan B. Keville, Esquire\**  
*Hooper Lundy & Bookman Inc.  
Los Angeles, CA*

### Introduction

The Medicare program's obligation to reimburse providers for a portion of unpaid beneficiary coinsurance and deductible obligations, commonly known as "bad debts," has historically engendered considerable litigation both at the administrative level and in court. The rules promulgated by the Centers for Medicare and Medicare Services (CMS) regarding when bad debts are reimbursable, which certainly are more extensive than guidance governing some other items and services, are sufficiently ambiguous that Medicare providers have often disagreed with fiscal intermediaries and CMS regarding how and when those rules are satisfied. These disputes often end up before the Medicare Provider Reimbursement Review Board (PRRB) and, with some degree of regularity, before federal courts. This state of affairs has only continued in recent years. In particular, in the last several years there has been a flurry of legal activity over two issues related to bad debt reimbursement: (1) whether patient accounts that a Medicare provider has pending with an outside collection agency (OCA) may be claimed as bad debt; and (2) whether Medicare reimburses bad debts associated with services reimbursed under a fee schedule.

Although, since the beginning of 2007, one federal appeals court has ruled against providers with regard to bad debts associated with accounts at an OCA and a federal district court has issued a ruling that bad debts associated with services paid under a fee schedule are not reimbursable, these issues cannot be considered resolved. These same issues are at play in cases pending in other venues and, as explained below, there are sufficiently compelling arguments supporting the providers that the courts involved may not feel constrained to follow prior decisions.

### Brief Background on Medicare Bad Debt

When receiving inpatient and outpatient hospital services, Medicare enrollees are responsible for paying coinsurance and deductible amounts.<sup>1</sup> The failure

of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by patients who are not Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are reimbursed by Medicare as “bad debts.”<sup>2</sup> The requirements for reimbursement for these bad debts are found in the Code of Federal Regulations (C.F.R.).

In order to qualify for reimbursement of Medicare bad debts, providers must show that the unpaid deductible and coinsurance amounts meet the following criteria:

- (1) The debt must be related to covered services and derived from deductible and coinsurance amounts;
- (2) The provider must be able to establish that reasonable collection efforts were made;
- (3) The debt was actually uncollectible when claimed as worthless; and
- (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.<sup>3</sup> These same criteria are reiterated in the Medicare Provider Reimbursement Manual, Part I (PRM-I).<sup>4</sup>

Section 310 of the PRM sets forth specific criteria for “reasonable collection efforts,” emphasizing that a provider’s effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. Reasonable collection efforts can include subsequent billings, follow-up letters, telephone calls, and personal contacts.

In regard to the criteria requiring the debt to be actually uncollectible when claimed as worthless, guidance is provided in the PRM: “If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.”<sup>5</sup> This has been referred to as the “presumption of uncollectibility.”<sup>6</sup> It relieves the provider of what would be an enormous burden of establishing, for each account, that sufficient collection efforts have been made so that the account may be written off as uncollectible. Instead, as long as reasonable collection efforts have been made, providers have been able to presume a debt uncollectible if 120 days have passed from the date of the first bill to the patient.

Despite the guidance offered in the C.F.R. and PRM regarding when Medicare will pay providers for bad debts, a large number of disputes arose because of inconsistent policies regarding bad debts being applied by Medicare fiscal intermediaries, which make payments to providers pursuant to contracts with CMS.

In order to minimize and eliminate these disputes, Congress enacted a “Bad Debt Moratorium” (Moratorium), which prohibited the Medicare program from making any changes in policies relating to bad debts that were in effect on August 1, 1987.<sup>7</sup> As discussed below, the Moratorium has come into play in multiple cases regarding patient accounts at an OCA.

## Claiming Bad Debts Associated with Accounts Sent to an Outside Collection Agency

Nowhere in the Medicare regulations is there any guidance on the impact of sending debts to an OCA. The PRM states only that “reasonable collection efforts” may include use of an OCA and that, if a facility elects to use an OCA, it must do so for both Medicare and non-Medicare patient accounts.<sup>8</sup> Neither the Medicare regulations nor the PRM address the timing of when bad debts can be claimed if an OCA is used. In other words, CMS has never stated through a regulation or manual provision that, so long as an account is with an OCA, no Medicare bad debt may be claimed for that account. Nevertheless, some Medicare fiscal intermediaries began taking the position that an account with an OCA cannot be considered uncollectible and therefore cannot be claimed as bad debt.

In *Battle Creek Health Systems and Trinity Health-Michigan v. Leavitt (Battle Creek)*,<sup>9</sup> the provider engaged in in-house collection efforts for 120 days and subsequently turned the unpaid accounts over to an OCA. The provider wrote-off the debts for accounting purposes even though these accounts were still pending with the collection agency.

The intermediary disallowed the claimed bad debts, finding that the hospital failed to demonstrate that the debts in question were uncollectible when claimed and that there was no likelihood of recovery in the future.

The CMS Administrator upheld the intermediary’s adjustments (overturning the decision of the PRRB), finding that accounts for which 120 days of in-house collection occurred may not be claimed as bad debt when subsequently referred to a collection agency. The CMS Administrator concluded that although there is a presumption that a debt that remains uncollected for 120 days is uncollectible, that presumption is permissive and the submission of a bad debt to a collection agency evidences an “expectation” of future collection on the debt. The Administrator found that it is “reasonable to expect a provider to demonstrate that it has completed its collection effort, including outside collection, before claiming debts as worthless.” The U.S. District Court for the Western District of Michigan affirmed the CMS Administrator’s decision when challenged by the provider.<sup>10</sup>

On appeal, the U.S. Court of Appeal for the Sixth Circuit granted summary judgment in favor of the U.S. Department of Health



and Human Services Secretary (Secretary), recalling testimony taken at the PRRB hearing where the Secretary established that it would “not have been unduly burdensome for Plaintiffs to determine the date that the collection agency found that the debts were uncollectible.”<sup>11</sup> Thus, according to the *Battle Creek* court, the Secretary’s application of the guidelines for bad debt reimbursement rules does not deprive providers of compensation for unpaid coinsurance and deductibles when an OCA is used, but instead simply withholds such compensation until the OCA has completed all efforts to collect delinquent accounts.<sup>12</sup> As a corollary, the *Battle Creek* court also opined that it was reasonable for the Secretary to require providers to furnish documentation showing when the relevant OCA deemed an account to be uncollectible.<sup>13</sup>

Until *Battle Creek*, administrative decisions regarding whether Medicare bad debts are allowable when pending with an OCA hinged on the specific facts and collection practices employed by the particular provider and the Administrator’s determination about whether, under the facts and circumstances presented, the provider exercised reasonable collection efforts and determined, based on sound business judgment, that there was no likelihood of collection in the near future. As illustrated in *Battle Creek*, CMS currently interprets the criteria set forth in the bad debt regulation and the PRM as requiring a cessation of all collection efforts as a precondition to a claim for Medicare bad debt. At least one federal appeals court now defers to CMS’ position.

A district court’s ruling in *Dameron Hospital Association v. Leavitt*<sup>14</sup> offers providers one potential basis for obtaining bad debt reimbursement for accounts still pending at an OCA, albeit a relatively limited one. In *Dameron*, the fiscal intermediary disallowed the provider’s bad debt reimbursement claim relying on the “presumption of collectability,” finding that the provider had not demonstrated that the debts were “actually uncollectible” when claimed as worthless because the accounts in question were still pending with an OCA when claimed. The provider appealed to the PRRB, which reversed the intermediary’s decision and held that “the mere ‘active’ status of an account with an outside collection agency, while suggestive of collectability of that account, is not in and of itself proof of value or collectability.” The CMS Administrator overturned the PRRB’s decision, finding that no amount of evidence could overcome the presumption of collectability arising from an “active” status of an account with an OCA. The Administrator reasoned that where a provider continues to attempt to collect a debt via a collection agency, it is reasonable to assume that provider still considers the debt to have value.

In evaluating this appeal, the U.S. District Court of the Eastern District of California determined that the Secretary’s decision was not in accordance with the law and that the decision would be reversed pursuant to the Administrative Procedure Act, 5 U.S.C. §§ 701 *et seq.* Relying on the bad debt Moratorium discussed above, the *Dameron* court concluded that the Secretary offered no substantial evidence in support of his position.<sup>15</sup> Conversely, the provider offered evidence proving that until the 2003 audit of fiscal year 1999, the intermediary had never rejected bad debt



## Editor’s Notes

**Kenneth R. Marcus, Esquire**  
*Honigman Miller Schwartz & Cohn LLP*  
Detroit, MI

I wish to express my appreciation to the authors who generously contributed their time, talent, and expertise resulting in the excellent and timely articles published in this edition of *The RAP Sheet*. *The RAP Sheet* encourages authors to submit articles on a wide variety of relevant topics. Authors wishing to contribute an article for publication in the next issue of *The RAP Sheet* should please submit their manuscript to me by **July 15, 2008**. If you have suggestions for articles or any other questions please do not hesitate to contact me at [kmarcus@honigman.com](mailto:kmarcus@honigman.com), or call me at (313) 465-7470.

claims under current hospital policy, unchanged since 1983. Thus, the court held the Secretary must pay the 1999 bad debt submission in full.<sup>16</sup>

*Dameron* is significant because it establishes that, in determining the applicability of the Medicare bad debt Moratorium, it is sufficient for the provider to offer testimony that it had not received a bad debt adjustment critical of its pre-August 1987 collection effort practices. If the provider is able to provide such testimony, the burden shifts to the intermediary to show that it had disagreed with the providers’ collection practices during the relevant audit period. In this connection, the court’s ruling in *Dameron* will only be useful for a facility that can show that

it: (a) was in the practice of using an OCA to collect delinquent obligations from both Medicare and non-Medicare patients prior to August 1987; and (b) that its intermediary permitted the provider to write off unpaid deductibles and coinsurance and to claim them as bad debt, even though such debts were pending with an OCA. The way that the decision is worded, *Dameron* will not benefit a provider that first started using an OCA to pursue delinquent accounts after August 1987.<sup>17</sup>

There is an argument that the bad debt Moratorium actually has a much broader reach than the way it was applied in *Dameron*. In particular, providers have taken the position that, regardless of a particular facility's practices, the Moratorium prevents the Secretary from changing the Medicare Program's bad debt policy that was in effect prior to 1987. This interpretation of the Moratorium is significant for the issue of whether a provider can claim bad debt associated with accounts that are pending with an OCA because there are facts indicating that the "presumption of collectability," upon which CMS' current policy is based, was not developed until after August 1987. This means that, if the Moratorium broadly prohibits the Secretary from changing bad debt reimbursement policies that were in place as of August 1987, the Moratorium precludes the disallowance of Medicare bad debt solely on the basis that the relevant patient accounts are pending with an OCA.

No court has yet accepted this broader application of the Moratorium as it relates to bad debt claimed for accounts pending with an OCA.<sup>18</sup> However, the scope of the Moratorium is currently pending before the U.S. District Court for the District of Columbia in the case of *Foothill Hospital – Morris L. Johnston Memorial v. Leavitt*,<sup>19</sup> along with the overall validity of the Secretary's general policy to deny bad debt reimbursement where the relevant accounts have been referred to an OCA. The court presiding over the *Foothill* case is not bound to follow either *Battle Creek* or *Dameron*, and could well view the relevant issues in a manner different than the courts that decided these previous cases.

Briefing in the *Foothill* case was completed in April 2008. In the *Foothill* case, the Secretary has re-asserted his view that accounts pending with an OCA cannot be deemed uncollectible and therefore cannot be claimed as bad debt. In addition, the Secretary has advanced an extremely narrow view of the force of the Moratorium, which relies on several federal appeals court cases. In response, the provider presented a fairly compelling case in support of its interpretation of the Moratorium, based on a plain language reading of the Moratorium statute. Further, the provider made strong points regarding the cases the Secretary cited in support of his position and, in fact, argued that the cases actually support a broad application of the Moratorium. The court likely will issue a ruling in *Foothill* sometime in the next few months.

## Availability of Bad Debt for Services Paid Under a Fee Schedule

More recently, fiscal intermediaries have been denying providers' claims for bad debt associated with certain services paid under Part B of the Medicare program using a fee schedule. This issue has most frequently come up with respect to physical, occupational, and speech therapy furnished on an outpatient basis by skilled

nursing facilities (SNFs) or hospitals that operate skilled nursing units. The intermediaries made these disallowances in accordance with a CMS policy to not make bad debt payments related to any services paid under a fee schedule. This policy apparently is based on the notion that bad debt is appropriately reimbursed only in connection with services that Medicare reimburses on a cost basis and that payments made under a fee schedule already afford providers some compensation for bad debt. Provider challenges to disallowances of this nature have now led to at least one federal district court decision on this issue.

*Abington Crest Nursing and Rehabilitation Center v. Leavitt*<sup>20</sup> involved a challenge to the Secretary's denial of reimbursement to several affiliated SNFs for bad debts associated with physical, occupational, and speech therapy. The PRRB originally overturned the intermediary adjustments disallowing the claimed bad debt, but the CMS Administrator reversed the PRRB.<sup>21</sup> The *Abington Crest* court affirmed the CMS Administrator's decision, finding that the Secretary's disallowance of the reimbursement claimed was based on a reasonable construction of the Medicare bad debt regulation, 42 C.F.R. § 413.80.<sup>22</sup>

The *Abington Crest* court recounted CMS' justification for its policy of bad debt related to fee schedule services. CMS asserts that the denial of bad debt reimbursement for services paid under a fee schedule is firmly rooted in the primary goal underlying bad debt reimbursement, e.g. to prevent the costs of caring for Medicare patients from being shifted to other payors.<sup>23</sup> According to CMS, under a fee schedule or reasonable charge methodology, Medicare does not share proportionately in an entity's incurred costs but rather makes payment for a specific service. The payment is not related to the cost of a service and thus, does not embody the concept of unrecovered costs due to uncollected amounts of deductibles and coinsurance. CMS asserts that payment of bad debt applies only to services reimbursed on the basis of reasonable costs or to services paid under one of Medicare's prospective payment systems that have a basis in reasonable costs that do not reflect Medicare payment of bad debts during a specified provider base period.<sup>24</sup> Further, according to CMS, fee schedules are based on provider charges or resources, which relate payments to the price the entity charges for services and therefore have historically reflected the providers' cost of doing business, including expenses such as bad debt.<sup>25</sup>

The *Abington Crest* court rejected arguments raised by the providers to the effect that the Secretary has been inconsistent in his application of bad debt reimbursement policy. The providers pointed out that the majority of services for which Medicare provides compensation are now paid based on some system of prospectively determined rates. By their very nature, prospective payment systems do not cover individual provider costs, which means that the "concept of unrecovered costs due to uncollected amounts of deductibles and coinsurance" does not logically apply to any type of prospective payment system. As such, if the purpose of bad debt reimbursement is related to providers recovering their individual costs, there is no reason CMS should reimburse bad debts related to any type of services for which Medicare pays on a prospective basis. Yet, bad debt reimbursement still is a component of most of Medicare's prospective



payment systems. In this connection, the providers argued that it was arbitrary for the Secretary to only deny bad debt reimbursement for services paid under a fee schedule.<sup>26</sup>

The court disposed of the Provider's argument by accepting CMS' assertion that there is significance to the fact that the rates paid under prospective payment systems are based on provider costs, while the rates paid under fee schedules are based on provider charges. CMS argued, and the court accepted, that provider charges take into account unpaid coinsurance and deductibles.<sup>27</sup>

The *Abington Crest* case is certainly a set back for providers who have faced, or are facing, disallowances of bad debts claimed for services reimbursed on a fee schedule basis. The court accepted that CMS' announced policy on this issue is reasonable without doing much probing. However, as *Abington Crest* is only a single federal district court opinion, it does not foreclose the issue. First, the providers appealed the district court's ruling in April 2008. Briefing has not yet commenced at the appellate level. Second, the arguments raised by the providers in the *Abington Crest*, while rejected by the U.S. District Court for the District of Columbia, are sufficiently compelling that a federal appeals court or other federal district court could find them persuasive.

In addition, although not explored in detail in the *Abington Crest* case, there is also the issue of whether CMS can furnish evidence to support its claim that fee schedule payment rates necessarily provide compensation for bad debt already. A court could view CMS' inability to furnish such evidence as a reason to discount the agency's position on the issue. There are currently cases pending before the PRRB on this issue in which the providers are, through the PRRB's discovery procedures, requesting that CMS provide documentary evidence in support of its policy to disallow bad debt reimbursement for fee schedule services.

Finally, it is important to note that in 2006, CMS amended the bad debt regulation to expressly incorporate the policy

precluding reimbursement of bad debts associated with services paid under a fee schedule.<sup>28</sup> A provider therefore arguably would have no basis, other than an allegation that the 2006 regulatory change is invalid, for claiming such bad debts on cost reports for any period subsequent to the effective date of the 2006 regulatory amendment. As discussed below, however, any such claimed bad debt would need to occur on the protested line of the cost report.

### Claiming Bad Debt in the Current Legal Climate

As alluded to above, while there has been abundant legal activity surrounding bad debt in recent years, this activity has not illuminated a particularly clear path for providers to follow with respect to claiming certain categories of bad debt. Certainly, it is clear that CMS takes the position that neither bad debt associated with accounts pending with an OCA nor with services paid under a fee schedule is reimbursable. Going forward, providers are faced with the prospect of capitulating to CMS' policies on these issues or fighting for impacted bad debt reimbursement through the administrative appeals process and then likely into court.

In light of the *Battle Creek* decision, with respect to costs reports that have not yet been submitted, it is advisable for providers to refrain from claiming bad debt associated with patient accounts that still are pending with an OCA unless they either disclose in a cover letter or set forth the bad debt on the protested line. As in *Dameron*, providers should determine if they can prove facts that would bring them within the operation of the Moratorium. This raises the issue of whether providers should recall pending accounts from their respective OCAs for the purpose of claiming Medicare bad debt. Such a strategy would require the recall from the OCA of all Medicare and non-Medicare patient accounts of a similar dollar value in order to comply with the requirement that collection efforts for both Medicare and non-Medicare patients be the same.

For providers that already have appeals pending that implicate the OCA issue, the *Battle Creek* decision is no reason to despair. As explained above, there remain compelling arguments in favor of the provider community on the issue, particularly the broader interpretation of the Moratorium that is being espoused by the plaintiff-provider in the *Foothill* case.

The situation with respect to bad debt associated with fee schedule-based services is similar. Certainly, because the regulation governing bad debt now expressly precludes reimbursement of bad debt for services paid under a fee schedule, providers effectively have no choice but to refrain from claiming such bad debt going forward, unless they use the protested line item.<sup>29</sup> However, for providers who have already claimed bad debt for fee schedule services rendered prior to the regulatory amendment, the *Abington Crest* case has not foreclosed their chance to collect reimbursement. The results of the appeal of the *Abington Crest* case and additional court cases arising from any of the currently pending PRRB cases involving the issue could alter the legal landscape in favor of providers.

### Conclusion

Both the *Battle Creek* and *Abington Crest* cases were blows against providers in the ongoing battle over Medicare bad debts.

However, that battle is far from over and there could potentially be good news for providers on the horizon. Nevertheless, providers will have to be patient in their pursuit of bad debts that were disallowed for being associated with accounts at an OCA or with fee schedule services because the law is continuing to develop.

\* *Jon P. Neustadter is a partner with Hooper Lundy & Bookman and can be reached at (310) 551-8151 or [jneustadter@health-law.com](mailto:jneustadter@health-law.com). Jordan B. Keville is an associate with Hooper Lundy & Bookman and can be reached at (310) 551-8103 or [jkeville@health-law.com](mailto:jkeville@health-law.com).*

- 1 42 U.S.C. §§ 1395e and 1395l.
- 2 42 C.F.R. § 412.115(a).
- 3 42 C.F.R. § 413.89.
- 4 PRM-I, § 308.
- 5 PRM-I, § 310.2.
- 6 *Dameron Hosp. Ass'n v. Leavitt (Dameron)*, 2007 WL 2288289, slip copy at 3 (E.D. Cal. 2007).
- 7 42 U.S.C. § 1395f note.
- 8 PRM-I, § 310.
- 9 498 F3d 401 (6th Cir. 2007).
- 10 *See* 423 F Supp.2d 755 (W.D. Mich. 2006).
- 11 498 F3d at 414.
- 12 *Id.* at 715.
- 13 *See id.*
- 14 2007 WL 2288289 (E.D. Cal. Aug. 8, 2007).
- 15 *See id.*
- 16 *See id.*
- 17 The Secretary appealed the District Court's ruling in *Dameron* to the Court of Appeals for the Ninth Circuit in October 2007. In response, the provider cross-appealed. However, the parties jointly stipulated to dismiss both appeal cases in November 2007. Accordingly, the district court's ruling in *Dameron* is now final.
- 18 At least one court, ruling on another issue related to bad debt, made statements supporting a broad view of the scope of the Moratorium. *See Hennepin Co. Medical Ctr. v. Shalala*, 81 F3d 743, 750-751 (8th Cir. 1996) (referring to the Moratorium and stating that, "[i]t appears that Congress merely sought to freeze a moment in time, forbidding the Secretary to change the [bad debt] criteria after that date, but allowing full enforcement of the policies in place before it."). The statement in *Hennepin* supports the notion that the Moratorium prohibited the Secretary from changing the criteria for bad debt reimbursement after August 1987.
- 19 Case No. 1:07-CV-00701-ESH.
- 20 --- F. Supp. 2d ---, 2008 WL 821751 (D.D.C. 2008).
- 21 *See Extencicare 99 Uncollect Co-In Dual Elig. Group v. Blue Cross Blue Shield Ass'n/United Government Services*, PRRB Dec. No. 2006-D36 (July 21, 2006), Medicare & Medicaid Guide (CCH) ¶ 81, 452 *rev'd*, CMS Adm'r (Sept. 12, 2006), Medicare & Medicaid Guide (CCH) ¶ 81,604.
- 22 During the fiscal year at issue in *Abington Crest*, the bad debt regulation was codified at 42 C.F.R. § 413.80 and not § 413.89, as is now the case.
- 23 2008 WL 821751 at \* 6.
- 24 *See id.*
- 25 *See id.*
- 26 *See id.* at \* 7.
- 27 *See id.*
- 28 71 Fed. Reg. 69624, 69712 (Dec. 1, 2006).
- 29 Given the 2006 regulatory change, the only purpose of the protested line at this point would be to preserve an appeal asserting that the regulatory change is invalid. Given that bad debt reimbursement is accomplished entirely through regulations, it will be quite difficult to convince a court that the regulatory change to exclude bad debt for fee schedule services is invalid.



## Regulation, Accreditation, and Payment Practice Group Leadership:

### Andrew D. Ruskin

Chair

Morgan Lewis & Bockius LLP  
1111 Pennsylvania Avenue, NW  
Washington, DC 20004-2541  
(202) 739-5960 • [aruskin@morganlewis.com](mailto:aruskin@morganlewis.com)

### Barry D. Alexander

Vice Chair – Educational Programs

Nelson Mullins Riley & Scarborough LLP  
4140 Parklake Avenue  
Glenlake One, Suite 200  
Raleigh, NC 27612-3723  
(919) 877-3802 • [barry.alexander@nelsonmullins.com](mailto:barry.alexander@nelsonmullins.com)

### Jolee Hancock Bollinger

Vice Chair – Membership

Franciscan Missionaries of Our Lady Health System  
5745 Essen Lane  
Baton Rouge, LA 70809-2158  
(225) 922-7447 • [JoleeBollinger@fmoths.org](mailto:JoleeBollinger@fmoths.org)

### James F. Flynn

Vice Chair – Research

Bricker & Eckler LLP  
100 S 3rd Street  
Columbus, OH 43215-4236  
(614) 227-8855 • [jflynn@bricker.com](mailto:jflynn@bricker.com)

### Kenneth R. Marcus

Vice Chair – Publications

Honigman Miller Schwartz & Cohn LLP  
660 Woodward Avenue  
2290 First National Building  
Detroit, MI 48226-3516  
(313) 465-7470 • [kmarcus@honigman.com](mailto:kmarcus@honigman.com)

# Commentary: The Administration's FFY 2009 Budget Proposes State-Specific Budget Neutrality for Geographic Reclassifications

Theodore N. Giovanis, Esquire  
T Giovanis & Company  
Highland, MA

The Administration's federal fiscal year (FFY) 2009 Budget includes a provision that would apply the geographic reclassification budget neutrality (BN) adjustment at the state level.<sup>1</sup> This objective would be achieved by adjusting the area wage indices (AWI) for the hospitals within a state to reflect the effect of the reclassifications for the hospitals of that state that reclassify.

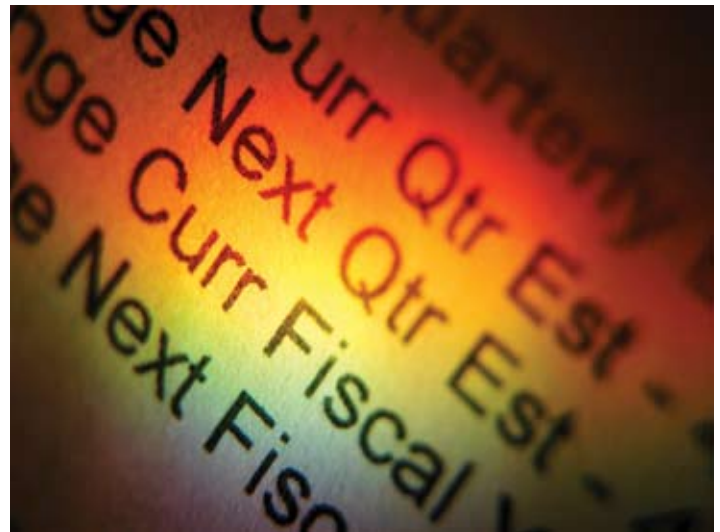
## The Proposal

Changes are made annually to the Medicare acute care prospective payment system (PPS). Many of those changes are required by statute to be made in a budget neutral (BN) manner. Under the BN concept, as the changes are made, the Medicare program must assure that aggregate payments after the change are no more nor no less than what those payments would have been had the change not been made. Changes to the AWI and the diagnosis related group (DRG) weights are required to be made in a BN manner as well as the implementation of the geographic reclassifications under § 1886(d)(8) and 1886(d)(10) of the Social Security Act.<sup>2</sup>

At present, the geographic reclassification BN adjustment is implemented as an adjustment that reduces the standardized payment rate that is paid to all PPS hospitals. Thus, all PPS hospitals pay for the added funding that the reclassified hospitals receive. Under the Administration's Proposed FFY 2009 budget, this would change to an approach that would require that this particular BN adjustment be accomplished on a state-specific (SS) basis.

The specific wording in the Administration's budget is as follows: "*Hospital Geographic Reclassification*: Apply the geographic reclassification budget neutrality requirement at the State level. Required budget neutrality would be achieved by adjusting the wage index for all hospitals within the State rather than reducing the standardized amount for hospitals nationwide."<sup>3</sup>

This type of requirement was previously discussed by the Senate Finance Committee in 2002 but did not receive serious attention. The concept was raised in the context of an effort to limit legislative reclassifications, and thus was an attempt by the Committee's leadership to gain leverage with which to limit these types of requests from Senate members.



The application of this type of change more broadly, such as to all reclassifications, however, could be difficult to accomplish and could have unanticipated effects. Of the many rural hospitals that receive reclassification, many are made to adjacent states. This type of provision, therefore, would have the effect of making all of the other hospitals domiciled in the state in which the reclassified hospitals are located pay for the reclassifications of those hospitals. This result could disproportionately impact rural providers, which in turn could decrease the probability of this change being adopted by the Senate. Conversely, raising the standardized payment rate, by not applying the reclassification BN adjustment to rates, could counter balance the SS reclassification adjustment.

For FFY 2008, the Centers for Medicare and Medicaid Services (CMS) adopted a change that applies the rural floor (RF) BN adjustment through a uniform adjustment to the AWIs rather than the previous adjustment to the standardized payment rates.<sup>4</sup> Apparently, from the CMS efforts in analyzing this FFY 2008 change, the CMS learned of the potential to apply the RF BN on a SS basis, which is what it has proposed for FFY 2009.<sup>5</sup> The effects of the application of the SS RF BN lead to dramatic differences in the applicable AWIs for hospitals within certain Metropolitan Statistical Areas (MSAs) and hospitals reclassified to a variety of MSAs. This occurs because in adopting this policy, the applicable SS RF BN adjustment factor follows the hospital if the SS adjustment is applicable in the state in which the hospital is domiciled.

With or without the adoption of the FFY 2009 SS RF BN adjustment and depending on how the President's proposal for a SS reclassification BN adjustment would be implemented, there could be an effect on the rural floor. Because of Medicare policy, the level of the RF is not only affected by the growth of the rural average hourly wage data but also by the reclassifications out of the rural area of the state.<sup>6</sup> Potentially, the RF reclassification effect could be segregated from the rural average hourly wage increase or AWI increase effect and applied separately. For FFY 2008, the RF BN adjustment is accomplished through a uniform adjustment to the AWIs of all hospitals in the country. If the reclassification effect were segregated and applied as the President has proposed, the RF states could potentially experience a

targeted BN reclassification decreasing adjustment and a related decrease in payments. Again, depending on the specifics of the calculation and application, if the FFY 2009 proposed rule SS RF BN adjustment and the President's SS reclassification adjustment were both adopted, there could be the potential for an additional reduction in AWIs for the effect of the adoption of the President's SS reclassification BN adjustment beyond those in the proposed rule for FFY 2009 that could potentially affect every state.

## Tactical Problems with the Reclassification SS BN Proposal

As follows, this proposal raises many implementation issues and ancillary questions:

- 1) *Reclassifications across state boundaries.* There are many situations where the geographic reclassifications cross state boundaries. Many of these reclassifications involve rural providers that are reclassified to the adjacent state because that is where they compete for labor. Under the proposed policy, the hospitals in the reclassified hospital's home state would pay dollar for dollar for the funding that the reclassified hospital received.
- 2) *Are census-based MSA changes de facto reclassifications?* When the MSAs are changed through the census process and those changes incorporate adjacent areas into a MSA, these changes are de facto reclassifications. When such changes involve annexing counties from an adjacent state, for instance from state A into a MSA (which, for the most part, was composed of counties/hospitals from another state—state B), there is a legitimate question why this change should not be treated as a reclassification under the proposal. Under the present rules or policy, all of the hospitals in the portion of the former MSA that were located in state B presently pay for the added funding for the new counties from the neighboring state A. If treated consistent with the President's recommended change, the hospitals actually domiciled in state A, as opposed to the hospitals from state B, would pay for these de facto reclassifications.
- 3) *Difficulties in administering the present system.* CMS presently faces challenges in administering the many complexities in the AWI application, some of which are attributable to reclassifications that often result in corrections or delays in timely publication of rules. In addition, in FFY 2008 CMS has begun to apply a portion of the BN calculation to the AWI rather than to the standardized payment rates, and for FFY 2009, has proposed to apply the RF BN on a SS basis. The Administration's proposal for a SS geographic reclassification BN adjustment would exacerbate and add further complexity.

Moreover, segregating the reclassification RF effect could make deriving the final AWIs enormously complex, which in turn could be wrought with problems. In addition to the other complexities, there could be multiple layers of uniform and state-targeted adjustments to the AWIs in developing the final AWIs, and such final AWIs would need to be determined before the overall BN adjustment (for the changes to the AWIs and DRG weights, generally) was performed. With the system this complex, there would be a greater risk of having duplicating effects among the various adjustments.

- 4) *Maintaining the same AWIs for reclassified hospitals in the same market could become impossible.* CMS attempts to assure that all of the hospitals that are reclassified to a particular area have the same reclassified AWI. This policy objective applies to the traditional reclassifications under Section 1886(d)(10), Lugar reclassifications under Section 1886(d)(8)(B), and Section 508 reclassifications. The Section 508 reclassifications have their own funding source and, therefore, may not be directly impacted by the President's proposed change. However, the Section 508 hospitals could be indirectly impacted if CMS continues to desire to achieve the same reclassified AWI for all of the reclassified hospitals. For example, if a hospital reclassifies into a MSA of an adjacent state, it could be affected by the proposed within state reclassification budget neutrality AWI adjustment of its home state, and the AWIs of the state into which it reclassifies could be affected by that state's SS BN adjustment. Therefore, because of these effects, there would be different AWIs for hospitals reclassified to and located in the same labor markets and such differences could be dramatic. As an illustration of this potential effect, the CMS FFY 2009 proposal for a SS RF BN would result in hospitals reclassifying into the same MSA having different AWIs (as much as four to six percentage points) even when they, theoretically, are in the same or similar labor market.

## Conceptual Problems with the Proposal

Included in the same budget proposal are other severe reductions in the payments to providers. This means that the payments to providers across the board will contract. At the same time, under this SS reclassification BN proposal, CMS would reduce payments for reclassifications that would affect states disproportionately depending upon the number and cost for the yield of reclassifications of the hospitals in those states. There are approximately 900-1,000 hospitals that are reclassified annually. These reclassifications and their related payments would be decreased randomly by state instead of an adjustment being universally applied as at present, and such reductions would be over and above the other reductions in payments proposed in the same budget. This proposal, therefore, seems to ignore the degree and location of the resultant payment contractions.

The geographic reclassification BN adjustment is by definition budget neutral. Therefore, there would, theoretically, be no net reduction in payments related to the implementation of this change. However, there could be reductions in other adjustments that are multipliers on the base Medicare payments, such as disproportionate share hospitals (DSH) and indirect medical education adjustments (IME), if those recipient hospitals have their net base payment (considering both the standard rate and AWI) reduced through the implementation of this proposal.

Taking the dollars for such a change from a national pool (as at present) is done in many areas of health policy. The Medicare outlier pool is funded by all hospitals and is disproportionately distributed to a subset of those hospitals. In addition, under the Medicaid program, the matching rates are different across states because many of the individual states do not have the tax base to support the required Medicaid expenditures for that state. These



approaches are similar in concept to the present situation with reclassifications.

A similar logic can be applied to the SS RF BN adjustment being proposed in rule making for FFY 2009. As proposed, instead of removing the funding for the adjustment from the total funding pool, it would be removed on a state-by-state basis, which is inconsistent with the policies for other parts of the payment system, as well as for other payments systems.

### Political Dynamics of the Change

Whether this reclassification SS BN proposal becomes actionable will depend upon the tone and desires of Congress. The reclassification BN adjustment takes money from all hospitals and gives it to the reclassified hospitals. Therefore, what happens could be a function of the net effect of the change on urban versus rural hospitals. Specifically, whether this proposal can be approved will be determined by the number of reclassifications and the related dollars for urban versus rural hospitals and by the effect of not having the negative effect of the BN adjustment in the standardized rates, as well as the effect on the other payments such as DSH and IME payments. Thus, it will be this net effect that will determine who wins and who loses. Generally, the House will want to protect the urban hospitals, and the Senate will want to protect the rural hospitals. It cannot be ignored that 2008 is an election year for the Presidency, the entire House, and one-third of the Senate. The potential for legislative changes this year also will depend upon whether Congress can move major Medicare legislation.

In addition, there is the complicating effect of the SS RF BN in the FFY 2009 proposed rule and whether that proposal will be adopted. These kinds of SS BN adjustments can be viewed in a “camel’s nose under the tent” context, asking where does one stop in making SS adjustments for the effects of changes in the payment system.

### Conclusion

The implementation of the proposed SS reclassification BN change does not appear to comprehend the many ramifications, some of which are discussed herein, and its implementation seems particularly problematic given the difficulty already faced by CMS in administering certain aspects of the program specifically with regard to the AWI and BN adjustments. Nevertheless, there is a possibility that this proposal, despite these serious implications, could be adopted. Therefore, the proposal is worthy of attention and monitoring, at least in the short term.

1 Department of Health and Human Services, *2009 Budget in Brief, Advancing the Health, Safety, and Well Being of Our People* (Feb. 2008).  
2 72 Fed. Reg. 47416 (Aug. 22, 2007).  
3 Department of Health and Human Services, *2009 Budget in Brief, Advancing the Health, Safety, and Well Being of Our People* (Feb. 2008).  
4 72 Fed. Reg. 47325 (Aug. 22, 2007).  
5 73 Fed. Reg. 23620 (Apr. 30, 2008).  
6 72 Fed. Reg. 47331-2 (Aug. 22, 2007).



### Practice Groups Staff

#### Trinita Robinson

Vice President of Practice Groups  
(202) 833-6943  
trobinson@healthlawyers.org

#### Emilee Hughes

Practice Groups Manager  
(202) 833-0776  
ehughes@healthlawyers.org

#### Magdalena Wencel

Practice Groups Administrator  
(202) 833-0769  
mwencel@healthlawyers.org

#### Kristina Hilton

Practice Groups Assistant  
(202) 833-0765  
khilton@healthlawyers.org

#### Mary Boutsikaris

Art Director/Graphic Designer  
(202) 833-0764  
mboutsik@healthlawyers.org

#### Alex Leffers

Graphics/Production Assistant  
(202) 833-0781  
aleffers@healthlawyers.org

## What's in an NPI? Everything!

*Karen D. Smith, Esquire*  
*Bricker & Eckler LLP*  
*Columbus, OH*

The National Provider Identifier (NPI) was created as a result of the mandate in the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The final rule adopting the NPI as the standard unique identifier for healthcare providers was published on January 23, 2004, and became effective May 23, 2005. All covered entities (except for small health plans) were to be in compliance by May 23, 2007. The lack of readiness on the part of the healthcare industry caused the Centers for Medicare and Medicaid Services (CMS, the enforcement agency for NPI) to develop a contingency plan that would allow covered entities to continue to work through problems with NPI implementation for twelve months following May 23, 2007.<sup>1</sup> CMS' contingency plan allowed the use of both the NPI and the Medicare legacy numbers on claims until May 23, 2008. By now, every healthcare provider or supplier should have an NPI and should be using the NPI in conjunction with its Medicare legacy number in submitting all claims.

### March Madness

The next step came on **March 1, 2008**, when CMS implemented the next phase of the use of an NPI. After March 1, 2008, claims that do not contain an NPI in the *primary provider field* are being rejected. This is true for claims filed on a CMS-1500 or on a Medicare FFS 837P (more commonly known as the UB-04). Prior to March 1, 2008, a claim that contained both the Medicare legacy number and a NPI number was paid regardless of which number was in the primary provider field. After March 1, 2008, the NPI must be in the primary provider field. Why is this important? Because as of **May 23, 2008**, CMS no longer pays claims that contain a Medicare legacy number. Medicare only pays claims that contain an NPI number.<sup>2</sup>

By imposing the **March 1, 2008**, deadline for placement of the NPI in the primary provider field, CMS forced providers to start seriously relying on their NPI number and gradually moving away from their Medicare legacy number. Providers were encouraged to make sure that their NPI corresponded to their correct Medicare legacy number in the Medicare NPI crosswalk. If a provider received notification that its NPI number and provider number were not matching or was aware that their carrier, fiscal intermediary, or A/B MAC was using a patch to allow the provider to be paid, the provider needed to correct the problem before May. The patch was a temporary measure only.

### May Mayhem

It is not yet known how many providers and suppliers are still having problems with NPIs. CMS reports that while over 90% of

claims are submitted using both an NPI and a Medicare legacy number, only a small number of claims are submitted using only an NPI number.<sup>3</sup> Providers should test their ability to use only an NPI by submitting claims (only a small number for the test) using only an NPI number in the primary provider field.<sup>4</sup> This test can determine whether the provider's NPI is matching the provider's Medicare legacy number in the Medicare NPI crosswalk. If the provider's Medicare legacy number and the provider's NPI number do not match on the Medicare NPI crosswalk, the claim will reject.<sup>5</sup> If providers did not take this opportunity to test their claims, there is potential for many providers to have significant cash flow delays.

If the claim is rejected and the provider has confirmed that the provider's correct information is entered into the National Plan and Provider Enumeration System (NPPES), the provider should contact its Medicare carrier, fiscal intermediary, or A/B MAC enrollment staff to diagnosis and fix the problem. If a corrected 855 form is needed to fix the problems, this may take a few months to correct, so it is important that the providers are diligently working on this problem.

### Problems with Matching or Rejection

There appeared to be many problems that will create payment problems, if they were not corrected prior to May. CMS published a MLN Matters to alert providers and suppliers about common problems.<sup>6</sup> Providers and suppliers should be alerted for the following common reasons for rejection.

1. Errors in Employer Identification Number in NPPES. This is the Employer Identification Number (EIN) that is connected to the legal name of the entity as noted by the Internal Revenue Service. If the EIN reported in NPPES does not match the EIN used by CMS, the provider must submit a CMS-855 to its Medicare contractor to correct the EIN.<sup>7</sup>
2. Invalid or incomplete data within the "Other Provider Identifiers" section of the NPPES application. What causes the problem here is that when some providers and suppliers completed their NPI applications, they did not know what numbers to include in this section so they left the section blank. Many providers did not understand the terminology (i.e., use of the term OSCAR). CMS has now corrected the terminology and the NPPES application contains the name OSCAR/Certification number. Most providers understand the number to be placed in this field is the provider's Medicare certification number. A provider should have queried the NPI registry and if their Medicare number was not in NPPES, the provider must complete it as soon as possible.
3. Another common problem in this area related to an invalid or incomplete entry in this field is when the provider or supplier gives its Medicare legacy number but fails to identify the type of number (OSCAR, UPIN, PIN). If that happens, there will not be a crosswalk match and the claim will reject. As recent as February, 2008, some providers are still "fixing" their information in NPPES to accurately identify their Medicare provider number as an OSCAR/Certification number. In some cases, this was a problem because the provider's staff that obtained



the NPIs was not the finance/billing staff and truly did not understand the language.

4. Another common problem in this field is that suppliers and providers are reporting numbers that do not belong to that provider or supplier. An example of this is a physician in a group will report the physician's UPIN number or PIN number and also the PIN number of the group to which the physician belongs. If this is the physician's individual NPI, the physician must report only the physician's individual PIN and UPIN numbers and not a group PIN here. This is such a common problem that CMS provides seven specific examples of what numbers to include and what not to include in the MLN Matters article.<sup>8</sup>
5. Another common error is failure to report a change of ownership within the required thirty days to the appropriate Medicare contractor. Providers are required to notify the appropriate Medicare contractor via the appropriate 855 form. The change of ownership process has not gone as smoothly as providers had hoped. In addition, if the change of name occurs with the change of ownership, as is often the case, the chances for rejection increase. Think about this for a minute. The provider goes into NPPES and updates its change of ownership information and change of name information right after the change of ownership or change of name occurs. The provider must file an 855 form with the appropriate Medicare contractor to change the Medicare information. The provider has thirty days to report the change of information and often

takes that long to gather all information to be submitted. Then the 855 form is sent to the appropriate Medicare contractor and goes into a stack for review. If there are any questions about the 855, there may be a request for additional information. Once the applicable Medicare contractor has complete information and processes the application, it will still take thirty to forty more days before the name change is made in the claims system. While the 855 is being processed, the name in the NPPES system is now different from the Medicare information; therefore, the crosswalk will not match and claims will be rejected.

One personal example is a recent case of mine involving a change of legal name for an entity that held multiple Part A provider numbers and one Part B number. There is a ninety-day period to report name changes. The Part A 855 forms were completed first and submitted to the Medicare contractor. The Part B 855 was still being completed when the Part A contractor called with an announcement that I had never heard before. According to the Part A contractor, this legal entity had submitted an 855 to the Carrier when the Part B supplier was established, and this was the first time this long-standing legal entity was entered into Medicare's PECOS system. Subsequently, but prior to the name change, this entity revalidated all of its Medicare information through the 855 process. However, because the Carrier was the first Medicare contractor to submit information under this entity's tax identification number in PECOS, the Medicare fiscal intermediary was unable to change the legal name associated with this entity's tax identification number in the PECOS system. Only the Medicare Carrier could make the change! What we were told is that the Carrier "owned" the tax identification number.

6. Finally, if the NPI number is not submitted in the correct loop electronically, then the claim may reject. CMS advises organizational providers to submit their NPI in 2010AA or 2010AB loop. The attending, operating, or other physicians should be identified in the 2310A, B, C loops respectively. If 2420A loop is used, the attending physician NPI must be submitted.<sup>9</sup>

To avoid having these problems, providers and suppliers needed to have reviewed their information in NPPES and compared it to their Medicare information. If the NPI information was correct but did not match their Medicare number, the only way to correct their Medicare information was by changing their information through the applicable 855 form. As mentioned above, this process can take several months to be processed and effective.

### **NPI Dissemination**

When physicians began obtaining NPIs, there was a lot of confusion as to whether the NPI number could be disclosed by another entity (i.e., could a hospital provide a NPI number to another hospital or provider/supplier?). CMS indicated that it would make healthcare provider data disclosable under the Freedom of Information Act (FOIA). On September 4, 2007, the NPI registry became operational and CMS posted the downloadable file on September 12, 2007.<sup>10</sup> The key data elements that are FOIA-disclosable are:

- NPI
- Entity Type Code
- Replacement NPI
- Provider Name
- Provider Other Name
- Provider Business Mailing Address
- Provider Business Location Address
- Healthcare Provider Taxonomy Code
- Other Provider Identifier<sup>11</sup>
- Other Provider Identifier Type Code
- Provider Enumeration Code
- Last Update Date
- NPI Deactivation Reason Code<sup>12</sup>
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information

User names and passwords are not required to query the NPI registry or to download files containing the NPPES FOIA-disclosable healthcare provider data. The NPI registry operates in a real time environment. This registry is found at <https://nppes.com.hhs>.

gov/NPPES/NPIRegistryHome.do. It is recommended that clients review their own information through this registry. Some clients have found that they have not used their legal name when applying for the NPI, and some have found that they have not identified the type of their Medicare number (OSCAR, UPIN, etc.).

## Conclusion

May 23, 2008, came in no time. Providers and suppliers still have much to do to be ready for claims submission using an NPI only. Attorneys who represent providers and suppliers should engage in conversations with clients to assess their readiness and encourage them to be testing claims submission by using only NPIs. Remember, while it is relatively easy to fix information in NPPES, if the Medicare information needs to be changed through the use of an 855 form, it could take several months to make the correction.

- 1 CMS website, *Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule*.
- 2 MLN Matters Number MM5858, Feb. 1, 2008.
- 3 CMS Communications 1/29/08.
- 4 MLN Matters Number SE0802, special edition.
- 5 MLN Matters Number SE0802, special edition.
- 6 MLN Matters Number SE0725.
- 7 This author has worked with several providers to correct EINs for providers. It is more common than most people would ever believe.
- 8 MLN Matters Number SE0725, p.4.
- 9 MLN Matters Number SE0725, p.4.
- 10 CMS website, NPI, *Data Dissemination*.
- 11 CMS is suppressing the field for EIN because some suppliers have inadvertently put their individual social security numbers in this field.
- 12 CMS has made the decision not to make a healthcare provider's data available if the NPI is deactivated.

## Chair's Corner

*Andrew D. Ruskin, Esquire*  
*Morgan Lewis & Bockius LLP*  
*Washington, DC*

Regulation, Accreditation, and Payment Practice Group (RAP PG) has been very busy this year. We have been involved in twelve different teleconferences this past year; several others are in development. We are close to finalizing a toolkit relating to the enrollment process, which will facilitate the completion of the Form 855 for RAP PG members. We held a very well-received lunch on April 9 at the Institute on Medicare and Medicaid Payment Issues, at which Rodney Whitlock spoke about current initiatives in Congress relating to Medicaid and Medicare. You are currently reading the second edition of *The RAP Sheet* published this fiscal year, and the content in this issue demonstrates our focus on high-caliber, timely analyses. We also have held monthly RAP PG leadership

calls, during which peers at a number of firms and institutions and representatives in government exchange ideas about current trends in regulation, accreditation, and payment, and discuss ideas for delivering content to members. Participation in these monthly meetings is always encouraged, and it is a great way to get a broader world view of matters that may be of interest to you. Please email me at [aruskin@morganlewis.com](mailto:aruskin@morganlewis.com), should you be interested in participating. Also, please note that RAP PG will be co-sponsoring a luncheon at the Annual Meeting with the Hospitals and Health Systems Practice Group entitled "Hindsight is 20/20: Evaluating the 2008 Top Ten Health Law Predictions." One of our active volunteers and an expert in RAP matters, Richard Sanders, will be part of the panel of speakers discussing current developments, as well as an assessment of the accuracy of previous prognostications (see the back cover of this newsletter for more information). We hope to see you there. I will be in attendance, and if you are there and have any ideas about how RAP PG can better serve your needs, by all means, please come up to me so that we can discuss in person.

# Much Ado About Very Little: The CY 2008 Medicare Physician Fee Schedule Final Rule and the Medicare, Medicaid, and SCHIP Extension Act of 2007

Sean A. Timmons, Esquire

Smith Anderson Blount Dorsett Mitchell & Jernigan LLP  
Raleigh, NC

The most interesting thing about the Calendar Year (CY) 2008 Physician Fee Schedule Final Rule<sup>1</sup> (the Final Rule) may not be what was included in the Final Rule, but rather, what was later delayed or undone by the Centers for Medicare and Medicaid Services (CMS) or the Congress. This article will address two key provisions that survived, as well as a few that did not. In particular, this article will address the finalized revisions to the independent diagnostic testing facility (IDTF) participation standards, and the changes regarding comprehensive outpatient rehabilitation facilities (CORFs) participation. Because there has already been extensive coverage of the finalized, then partially delayed, anti-markup rule changes<sup>2</sup> this article will not address that issue. Finally, this article will discuss some policy areas addressed in the preamble to the Final Rule, and the effect of the Medicare, Medicaid, and SCHIP Extension Act of 2007<sup>3</sup> on certain provisions of the final rule.

## IDTF Issues

In the Final Rule, CMS finalized certain changes to the performance standards for IDTFs. The changes modify the requirements with respect to: insurance maintained by IDTFs; the timing of reporting certain reportable events; documenting the response to patient questions and complaints; oversight of IDTF sites (including mobile sites) by the supervising physician; initial enrollment date and retrospective billing; the exclusion of hotels and motels as appropriate IDTF sites; and a prohibition on shared space and equipment. Each of these revisions is briefly discussed below.

## Insurance Requirements

The Final Rule modifies 42 C.F.R. § 410.33(g)(6) to require that an IDTF obtain and maintain a comprehensive general liability insurance policy with coverage of at least \$300,000 per location and \$300,000 per incident. Failure to maintain the insurance will result in revocation of billing privileges retroactive to the date that the insurance lapsed. Furthermore, IDTFs are now required to provide contact information for the IDTF's insurer to CMS and to notify the CMS-designated contractor in writing in the event of any policy changes or cancellations.<sup>4</sup> The effect of this provision will be to provide more specificity with respect to the required

insurance and to allow CMS to track more accurately the insurance status of enrolled IDTFs.

## Reporting Requirements

The Final Rule revises 42 C.F.R. § 410.33(g)(2) to require that certain changes to IDTF enrollment information must be reported to the CMS contractor within thirty days of the change, while any other changes to enrollment information will be subject to ninety-day notice. The changes that must be reported within thirty days are changes in ownership, changes of location, changes in general supervision, and adverse legal actions. Any other changes to information on the enrollment application must be reported within ninety days.<sup>5</sup> Previously, all changes were to be reported within thirty days. The effect should be to ease some of the reporting burden on IDTFs while still allowing CMS to monitor effectively the status of enrolled IDTFs.

## Requirements Regarding Documentation of Patient Complaints

The Final Rule revises 42 C.F.R. § 410.33(g)(8) to require that IDTFs must document and maintain patients' written clinical complaints and the responses to those complaints at the physical site of the IDTF (although mobile IDTFs must store the documentation at their home office). Such documentation must include: identifying information of the beneficiary, the date the complaint was received, the name of the person receiving the complaint, a summary of actions taken to resolve the complaint, and a record of any investigation undertaken.<sup>6</sup> This revision creates a specific documentation requirement with respect to the IDTF's obligation to respond to complaints.

## Requirements Regarding Physician Supervision

The Final Rule revises 42 C.F.R. § 410.33(b)(1) by deleting the requirement that the supervising physician be responsible for all administrative and regulatory issues arising at the IDTF. It further clarifies that in limiting the general supervision responsibility to no more than three sites, each mobile unit must be counted as a site.<sup>7</sup> This may have the effect of forcing IDTFs that have a number of mobile units to increase the number of physicians with supervisory responsibilities.

## Requirements Regarding Enrollment Date

The Final Rule creates a new 42 C.F.R. § 410.33(i) that states that the IDTF's enrollment date is the date on which the applicable Medicare contractor receives an enrollment application that is sufficiently complete for it to process to approval. It further provides that Medicare will pay for services provided on or after the later of the IDTF's enrollment date or the date that it first starts seeing patients at the enrolled location.<sup>8</sup> The effect of this provision will be to limit the period of retroactive billing for newly-enrolled IDTF sites. It also appears possible that the appropriate retroactive date will be uncertain during the application process, as it is relatively common that Medicare contractors seek additional information after the initial submission of an application, and the "enrollment date" will not occur until the contractor

determines that it has sufficient information to process the IDTF's application.

## Prohibition of Use of Hotels or Motels

The Final Rule revises 42 C.F.R. § 410.33(g)(3) to expressly state that a hotel or motel room is not a suitable location for an IDTF.<sup>9</sup> This revision could have a significant effect on IDTFs providing sleep studies.

## Prohibition against Sharing Location and Equipment

Finally, the Final Rule creates a new 42 C.F.R. § 410.33(g)(15) that prohibits IDTFs from sharing a practice location with another Medicare-enrolled individual or organization, leasing or subleasing their operations or practice locations to another Medicare-enrolled individual or organization, or sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled organization. This restriction is not applicable to hospital-based or mobile IDTFs.<sup>10</sup> In addition, there is a one-year delay (to January 1, 2009) in applicability of the location-sharing provision for IDTFs that are currently sharing a location with another Medicare-enrolled individual or organization.<sup>11</sup> This provision appears to be a continuation of CMS' concerns over leases and purchased test arrangements that allow physicians to bill for diagnostic tests that they order.

## CORF Issues

The Final Rule adopts several provisions related to the provision of services to Medicare beneficiaries by CORFs. The Final Rule addresses the scope of services that may be covered when provided in a CORF setting, the physician services included within the scope of CORF services, clarifications to respiratory therapy services, the scope of social and psychological services that may be provided by a CORF, nursing care services, drugs and biologicals provided in a CORF setting, supplies and durable medical equipment (DME) supplied within a CORF setting, certain technical corrections related to payment for CORF services, and payment for vaccines supplied in the CORF setting. Following is a brief discussion of key issues in the Final Rule related to CORFs.

## Covered Services

The Final Rule revises 42 C.F.R. § 410.105(c) to clarify that CORF services are only covered if they relate directly to the rehabilitation of injured, disabled, or sick patients.<sup>12</sup> The implication of this change is that it is no longer sufficient for coverage in the CORF setting that the services be consistent with a written plan of care established for the patient. Any such services must also be directly

for the rehabilitation of the patient, and may not be for the purpose of providing care unrelated to the patient's rehabilitation.

## Physician Services

The Final Rule revises 42 C.F.R. § 410.100(a) to clarify that CORF facility physician services are administrative in nature. Diagnostic and therapeutic services provided by physicians in the CORF setting are traditional Part B physician services, not CORF services, and are to be billed as such.<sup>13</sup>

## Respiratory Therapist Services

The Final rule revises 42 C.F.R. § 410.100(e) to remove certain services from the list of services that can be provided by a respiratory therapist.<sup>14</sup> This change reflects the concern of CMS that only physicians should provide services that include "diagnostic evaluation," "management," and the performance of diagnostic tests.

## Social Worker and Psychologist Services

The Final Rule revises 42 C.F.R. §§ 410.100(h) and (i) to limit the scope of services that may be provided by social workers and psychologists within a CORF, and to combine those sections into a single section 410.100(h). CMS' concern was that prior to the revisions, the regulations included a scope of services that would have permitted payment for services related to the treatment of mental illness in Medicare beneficiaries, rather than social or psychological issues relating directly to the patients' rehabilitation.<sup>15</sup>

## Recodification

The Final Rule makes several revisions to the Code of Federal Regulations to conform the regulations relating to payment for CORF services to fee schedule payment rather than cost-based payment.<sup>16</sup> The payment methodology was changed by statute in 1999, but the regulations have never been fully revised to reflect the changes.

## Conditions of Participation

Finally, the Final Rule revises the CORF conditions of participation at 42 C.F.R. § 485.51 to permit CORFs to provide vaccines to Medicare beneficiaries.<sup>17</sup> While this seems inconsistent with the revisions specifying that services provided in a CORF must relate directly to rehabilitation, it does further the goal of increasing beneficiaries' access to vaccines.

## Policy Issues Addressed in the Final Rule

The Final Rule devotes substantial discussion to the Physician Quality Reporting Initiative (PQRI), and, in particular, the methodology for selecting codes to be added. The PQRI is a voluntary initiative under which physicians will receive incentive





payments for reporting on quality indicators identified by CMS. There were seventy-four quality indicators for 2007, including such items as providing high blood pressure control for diabetes patients, providing beta-blocker therapy for coronary artery disease patients with a prior myocardial infarction, and a spirometry evaluation of patients with chronic obstructive pulmonary disease. In the Final Rule, CMS discussed its process for selecting codes to add to the PQRI list, which involves seeking input from the National Quality Forum and the AQA Alliance.<sup>18</sup> In addition, CMS identified new codes to be added to the PQRI list for 2008, which include measures submitted by the American Medical Association Physicians Consortium for Performance Improvement and a smaller number of codes submitted by other entities.<sup>19</sup>

In addition, CMS discussed different methodologies for allowing physicians to submit PQRI data. Currently, data on the quality indicators is submitted together with claims. However, CMS sought input on whether the information might be submitted either by registries that would collect the data from multiple practices and submit it to CMS, or by creating a mechanism whereby the data would be mined from electronic health records. While CMS did not finalize any new mechanisms for data collection, it did state that it would test registry- and EHR-based mechanisms during 2008.<sup>20</sup>

The Final Rule also identified additional CPT codes that will be considered “designated health services” for purposes of the Stark law and implementing regulations, and deleted certain CPT codes from the list to conform to changes in Medicare payment policy and CPT coding. One code was added for physical therapy, occupational therapy, and speech language pathology services; one for vaccines that are excepted from the list of DHS; and the rest of the added codes were for radiology and radiation therapy. All of the deleted codes were for radiology and other imaging services.<sup>21</sup>

### What Congress Left on the Cutting Room Floor

There were several issues addressed in the Final Rule that were undone by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (the MEA).

Most obviously, the Final Rule calculated that the fee schedule update for calendar year 2008 would be approximately -10.1%.

The MEA specified that from January 1, 2008, through June 30, 2008, the fee schedule update would be 0.5%.<sup>22</sup> This is great news for physicians and other Medicare suppliers, but leaves open the question of how Medicare services will be reimbursed from and after July 1, 2008.

The Final Rule also announced that incentive payments to physician furnishing services in physician scarcity areas would terminate by statute after December 31, 2007.<sup>23</sup> Once again, the MEA moves the termination date of the program to June 30, 2008.<sup>24</sup>

The Final Rule announced that carriers would no longer make payment to independent laboratories for the technical component of physician pathology services provided to hospital patients after December 31, 2007.<sup>25</sup> The MEA extended such payment to June 30, 2008.<sup>26</sup>

Finally, the Final Rule announced that exceptions to the outpatient therapy cap for services provided in outpatient hospital departments will terminate as of December 31, 2007.<sup>27</sup> The MEA extended the exceptions to June 30, 2008.<sup>28</sup>

### Conclusion

While the most important provision of the Final Rule, the physician payment update, was ultimately undone by Congress, the Final Rule contained provisions that are likely to have a significant effect on IDTF suppliers, and some changes of importance to CORFs. It will be interesting to see how Congress will address the physician fee schedule update upon the expiration of the current stop-gap, particularly as this year is an election year.

1 72 Fed. Reg. 66222 (November 27, 2007); as amended by 73 Fed. Reg. 404 (January 3, 2008), 73 Fed. Reg. 2431 (January 15, 2008) and 73 Fed. Reg. 2433 (January 15, 2008).

2 See, 72 Fed. Reg. 66222, 66306 *et seq.*

3 Pub. L. No. 110-173, Dec. 29, 2007.

4 72 Fed. Reg. at 66285.

5 *Id.* at 66286.

6 *Id.*

7 *Id.* at 66287-8.

8 *Id.* at 66288-9.

9 *Id.* at 66289-90.

10 *Id.* at 66290-93.

11 *Id.* at 66291.

12 *Id.* at 66294.

13 *Id.*

14 *Id.* at 66295-97.

15 *Id.* at 66297-9.

16 *Id.* at 66302-3.

17 *Id.* at 66303 (to be codified at 42 C.F.R. § 485.51(c)).

18 *Id.* at 66339-44.

19 *Id.* at 66344-50.

20 *Id.* at 66350-3.

21 *Id.* at 66372-3.

22 MEA, § 101(a)(1).

23 72 Fed. Reg. at 66293.

24 MEA, § 102.

25 72 Fed. Reg. at 66355.

26 MEA, § 104.

27 72 Fed. Reg. at 66356.

28 MEA, § 105.

## The PRRB Common Issue Related Party Rule Assumes Prominence

*Kenneth R. Marcus, Esquire\**

*Honigman Miller Schwartz & Cohn LLP*

*Detroit, MI*

Since 1983, the Medicare Regulations have provided that “any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal.”<sup>1</sup> This requirement is known as the common issue related party rule (CIRP Rule). If published decisions are any indication,<sup>2</sup> over the past twenty-five years the Provider Reimbursement Review Board (PRRB) does not appear to have devoted significant attention to the CIRP Rule. Of course, PRRB jurisdictional decisions typically are not published, and thus, it is difficult to determine whether and to what extent the PRRB has applied the CIRP Rule over the years. As practitioners before the PRRB will verify, however, the PRRB recently has given the CIRP Rule heightened scrutiny. Moreover, a revised final rule governing PRRB procedure published as this article went to press introduces the term “mandatory appeals” in the context of CIRP appeals.<sup>3</sup> Providers and their representatives, therefore, must be familiar, and comply, with the CIRP Rule.

### Legal Bases for the CIRP Rule

The legal bases for the CIRP Rule are the Medicare Statute, the Medicare Regulations, and the PRRB *Instructions*.

#### *The Medicare Statute*

The Medicare Statute provides as follows:

Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) [group appeals] must be brought by such providers as a group with respect to any matter involving an issue common to such providers.<sup>4</sup>

#### *The Medicare Regulations*

The Medicare Regulation in effect as this article went to press provides as follows:

##### ***Providers under common ownership or control.***

Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, \$50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other

providers in the group must file a separate hearing request (see §405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.<sup>5</sup>

The Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), stated as follows regarding the purpose of the CIRP Rule:

[W]e have changed the regulations to state that effective April 20, 1983, an appeal to the Board or an action for judicial review by providers that are under common ownership or control, as that phrase is defined in § 405.427 of the regulations, must be brought by the providers as a group with respect to any matter involving an issue common to them. Section 405.427 states that common ownership exists if an individual or individuals possess significant ownership or equity in the provider and in the institution or organization serving the provider. Control exists if an individual or an organization has the power, directly or indirectly, to influence significantly or to direct the actions or policies of an organization or institution whether or not that power is actually exercised.<sup>6</sup>

The final rule published on May 23, 2008, effective August 21, 2008, and applicable to all appeals pending as of, or filed on or after August 21, 2008, provides as follows:

- (1) *Mandatory use of group appeals.*
- (b) *Usage and filing of group appeals.* (1) *Mandatory use of group appeals.* (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is \$50,000 or more in the aggregate, must bring the appeal as a group appeal.
- (ii) One or more of the providers under common ownership or control may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the \$50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.
- (iii) A group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control.<sup>7</sup>



Moreover, the revised regulation requires that a provider appeal request identify whether providers under common ownership and control have appealed the same issue.<sup>8</sup>

### The PRRB Instructions

The PRRB *Instructions* provide as follows:

If you and other providers are under common ownership or control and have an issue in common, you must file a group appeal if the amount in controversy is \$50,000 or more. These are known as Common Issue-Related Party or CIRP appeals and are “mandatory” group appeals. If the amount in controversy is less than \$50,000, then you and the other providers may file individual appeals as long as you meet all jurisdictional requirements, including the \$10,000 threshold, for individual appeals before the Board. A CIRP appeal is separate from and is not a part of a non-CIRP appeal.<sup>9</sup>

### Discussion

Recently, the PRRB has proactively reviewed group appeals to identify providers that are part of systems or chains, and where the PRRB has identified such providers it has issued a directive that the provider submit an affidavit that:

- Identifies all hospitals owned by the corporation in the FYE under appeal;
- States that commonly owned providers are not participating in other group appeals or individual appeals of the issue and that the PRRB has not issued a decision on the issue for any other providers in the chain;
- States that other members of the chain that are not pursuing the issue waive their right to do so;
- Authorizes a representative for the entire corporate organization; and
- Identifies commonly owned providers that have not received NPR's.

As referenced above, the information that the PRRB has sought to elicit via such an affidavit is now required to be included in a request for an appeal under the revised rule.<sup>10</sup>

Thus, as witnessed by the significantly revised PRRB regulations and the recent change in PRRB practice, the CIRP Rule has been elevated to a prominent level.

As with all PRRB rules, formal and informal, providers and their representatives are well advised to comply with the CIRP Rule. A number of unanswered questions remain, however, regarding the CIRP Rule, which pose a challenge to providers. For example, there is a question of timing. PRRB appeals typically consume years. Thus, an important question is *when* the “common ownership and control” is determined. That is, the status of a provider may change during the course of a typically protracted PRRB appeal. Is the status determined as of the day the provider files the appeal? What if the provider is part of a system on the day it

files the appeal, but during the course of the appeal ceases to be part of a system? Conversely, what if a provider becomes part of a system after it has filed its appeal?

There is also the substantive question on how “common ownership and control” is to be determined. Although the preamble to the 1983 rule referenced the related organization rule,<sup>11</sup> it was not referenced in the 1983 regulation, nor is it referenced in the revised May 23, 2008, regulation. Presumably the related organization regulation governs. Still, and even under that regulation, there is no bright line test. For example, a provider may be partly owned by a system, or it may be a third tier member of a system off on the periphery.

There is also the practical question of whether one or more providers in a particular state appealing an issue that is specific to that state, such as a bad debt issue involving “dual eligibles,” must include themselves in a CIRP group with related providers in other states that may or may not have the identical issue.

Of course, the ultimate question is whether the PRRB will apply and enforce the CIRP Rule in a manner that implicates PRRB jurisdiction. That is, if a provider that otherwise satisfies the jurisdictional requirements for an appeal<sup>12</sup> does not comply with the CIRP Rule, will the PRRB dismiss such an appeal on jurisdictional grounds, and will such a dismissal be affirmed by the CMS Administrator and the federal courts? As the aforementioned quotation to the 1983 preamble to the CIRP Rule suggests, the narrow purpose of the CIRP Rule was to prevent mischief by chain organizations that would seek to insulate all but one member of a chain by having only one member of the chain appeal an issue. If the appeal failed, the three-year reopening period likely would have expired, and thus, the other members of the chain would be insulated from liability. To the extent such a concern is realistic or legitimate, the PRRB and CMS clearly have expanded the scope of the CIRP Rule beyond such a concern. Finally, in light of the limited resources of the PRRB and its admitted challenge in managing its caseload, estimated currently at 6,500 appeals, one must wonder why devoting time and resources to “policing” the CIRP Rule, some twenty-five years after its adoption, now is seen as a priority.

\* *Kenneth Marcus is a partner at Honigman Miller Schwartz & Cohn LLP, Detroit, MI. Mr. Marcus is the current Vice Chair of Publications of the Regulation, Accreditation, and Payment Practice Group of AHLA. This article is not intended to furnish legal advice. Readers wishing to discuss the subject of this article may contact Mr. Marcus at [kmarcus@honigman.com](mailto:kmarcus@honigman.com)*

1 42 C.F.R. § 405.1837.

2 An electronic search of the term “CIRP” in published PRRB decisions reveals five decisions.

3 42 C.F.R. § 405.1837(b)(1). 73 Fed. Reg. 30189, 30251.

4 42 U.S.C. § 1395oo(f)(1).

5 42 C.F.R. § 405.1837.

6 48 Fed. Reg. 39752 (Sept. 3, 1983).

7 42 C.F.R. § 405.1837(b)(1).

8 42 C.F.R. § 405.1835(b)(4).

9 The Board *Instructions* can be found online at [www.cms.hhs.gov/PRRBReview/Downloads/PRRB\\_Instructions\\_March\\_03.pdf](http://www.cms.hhs.gov/PRRBReview/Downloads/PRRB_Instructions_March_03.pdf).

10 42 C.F.R. § 405.1835(b)(4).

11 42 C.F.R. § 413.17.

12 42 U.S.C. § 1395oo.

## Upcoming Teleconferences

### Two-Part Series CMS' Final Rule Revising Provider Reimbursement Review Board Appeal Procedures

*Sponsored by the Regulation, Accreditation, and Payment Practice Group*

#### Part I: CMS' New PRRB Rules: What You Need To Know Now

Tuesday, June 17, 2008

#### Part II: CMS' New PRRB Rules: Select Topics

Thursday, July 31, 2008

On May 23, 2008, the Centers for Medicare & Medicaid Services published the long-awaited final rule revising the PRRB appeal process. This action represents the first significant revision of the PRRB rules in more than 30 years. The rule, which is effective for appeals pending as of, or filed on or after, August 21, 2008, contains several new and revised provisions with which providers and their representatives must become familiar.

Part I will identify and discuss the major provisions of CMS' Final Rule revising PRRB appeal procedures.

Part II will discuss in more detail select provisions of the new rules. If the Board's own revised Instructions are issued, they will be discussed as well.

### CMS' Proposed Revisions to the Medicare Advantage and Prescription Drug Benefit Programs: Practical Perspectives on Important Marketing and Pricing Changes

Thursday, July 10, 2008

12:30 - 2:00 pm Eastern

*Sponsored by the Medicare Part D Task Force (a joint endeavor of the Fraud and Abuse, Self-Referrals, and False Claims; Health Information and Technology; HMOs and Health Plans; Life Sciences; Long Term Care; Regulation, Accreditation, and Payment; and Teaching Hospitals and Academic Medical Centers Practice Groups)*

On May 16, 2008, CMS issued a Proposed Rule containing significant changes to the Medicare Advantage and Prescription Drug Benefit Programs. This teleconference will highlight significant proposed changes in various areas including marketing, drug pricing and cost reporting. The speakers will provide expert practical insight that will assist stakeholders to

understand the potential impact of the proposed changes. The teleconference will cover the following issues, among others:

- Impact on sales and marketing practices;
- Problem solving solutions to handling reporting requirements, complaints, and investigations;
- State oversight of broker activities;
- Broker training and compensation;
- Limiting scope of appointments with prospective enrollees;
- State and federal jurisdiction issues related to health plans;
- Proposed price reporting requirements for Part D and Retiree Drug Subsidy; and
- Impacts on pricing relationships between manufacturers, PBMs, pharmacies, and Part D sponsors.

### How to Remain Compliant When Physician Recruitment Arrangements Go Awry

Tuesday, July 29, 2008

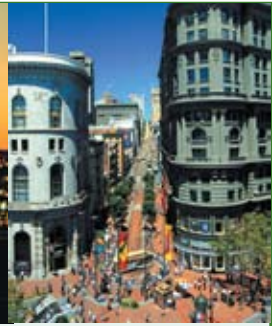
*Co-sponsored by the Healthcare Liability and Litigation, Hospitals and Health Systems, In-House Counsel, and Physician Organizations Practice Groups*

This teleconference will provide guidance for providers on remaining compliant with federal laws when physician recruitment arrangements cannot be implemented as originally documented, due to breach of contract or other reasons. The teleconference will focus on questions such as:

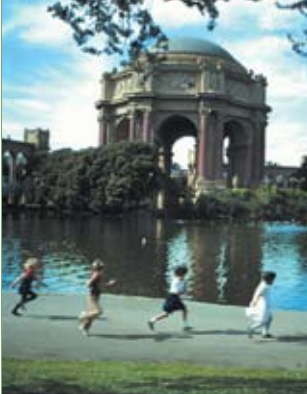
- If the physician is going to remain in the community as a potential referral source, how can the provider resolve the situation without exposing itself to "stay in the favor" arguments or an allegation of an improper inducement?
- Is the hospital obligated to sue the physician for unpaid loans, for example, or can the hospital give up some of its claim for past benefits conferred to reach a settlement?
- Has the government chosen to impose sanctions on either party when a physician recruitment agreement is not performed as originally documented, and if so, what factors led to that decision?
- What factors has the government looked to in various cases to determine compliance when parties attempt to resolve contractual disputes and/or changes in circumstances that make performance as originally documented more difficult or impracticable?

**Unless otherwise noted, all teleconferences are held 1:00-2:30 pm Eastern.**

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# San Francisco



## Regulation, Accreditation, and Payment and Hospitals and Health Systems Practice Groups Joint Annual Luncheon

at the  
2008 Annual Meeting  
San Francisco, CA

Sponsored by **Deloitte.**

Tuesday, July 1, 2008

### Hindsight is 20/20: Evaluating the 2008 Top Ten Health Law Predictions

The luncheon will feature a panel discussion on the status of the AHLA's January 2008 "top ten" predictions on changes to the health law landscape, as well as commentary about the critical issues that few foresaw.

#### Panelists:

**Marc D. Goldstone, Esquire**  
Community Health Systems Inc.  
Franklin, TN

**William W. Horton, Esquire**  
Haskell Slaughter Young & Rediker LLC  
Birmingham, AL

**Richard D. Sanders, Esquire**  
Balch & Bingham LLP  
Atlanta, GA

**Joseph V. Truhe, Jr., Esquire**  
San Juan Capistrano, CA

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1025 Connecticut Avenue, NW  
Suite 600  
Washington, DC 20036-5405