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HEALTHCARE: ILLINOIS ADOPTS LAW MANDATING HOSPITALS TO REPORT MEDICAL ERRORS

A new law, the Illinois Adverse Health Care Events Reporting Law of 2005, requires hospitals and ambulatory surgical centers ("ASC") to report certain serious adverse health care events to the Illinois Department of Public Health (the "Department"). The purpose of this law is to establish a health care reporting system to facilitate quality improvement within the state's health care system. The law enumerates certain adverse events which must be reported within 30 days of discovery, such as: surgery on a wrong body part; death following surgery on a previously healthy patient; patient death or disability associated with the use of a contaminated device or drug; patient suicide or attempted suicide while an inpatient in a facility; medication errors resulting in death or disability; patient falls resulting in death or disability; and maternal death or disability associated with labor or delivery in a low-risk pregnancy.

The reports may be filed electronically in a prescribed form and must identify the facility where the event occurred, but not the names of the patients, employees or health care providers involved. Following the occurrence of an adverse event, the health care facility must conduct a root cause analysis of the event. Following the analysis, the health care facility must (1) implement a corrective action plan to address the findings of the analysis or (2) report to the Department any reasons for not taking corrective action. A copy of the findings of the root cause analysis and a copy of the corrective action plan must be filed with the Department within 90 days after the submission of the report to the Department. After its review, the Department will communicate its recommendations to the facility. An annual report of adverse events will be issued that will describe the events reported by facility and recommendations for modification of state health care operations. This report will be available to the public. However, the findings of root cause analyses and other records created by the Department will not be discoverable.

Hospitals and ASCs must have their reporting system fully operational by January 1, 2008. The Hospital Licensing Act was

amended to provide for notice and hearing if a hospital does not comply with the reporting law. In the event that a hospital is found to have substantially failed to comply with the law, the hospital's license to operate may be suspended or revoked. An ASC that fails to comply with the law may be assessed up to \$500 per violation per day until the violation is corrected or action is undertaken to suspend or revoke its license to operate, whichever comes first.

HEALTHCARE: ILLINOIS LAW NOW REQUIRES 30-DAY NOTICE BEFORE HEALTH CARE PRACTICES AND FACILITIES CEASE THEIR OPERATIONS

Effective this year, a new Illinois statute requires that at least 30 days before a health care practitioner or health care facility cease operations, a public notice must be published in a newspaper of general circulation in the area where the practitioner or health care facility is located. The law applies to medical offices, health care clinics, group practices and ambulatory surgical centers, as well as any entity where patients receive health care services. The notice must include information explaining how patients may access copies of their medical records.

KRHD NOTES

Philip L. Pomerance will speak at the American Health Lawyers' Association Annual Physician Law Conference and Annual Hospital Law Conference in Las Vegas, Nevada, on February 5 and 6, 2007. Phil's topic will be "Spilling The Beans: Protecting Yourself and the Attorney-Client Privilege During an Investigation." Phil is also teaching a seminar in the Winter Term at the Law School of Loyola University, Chicago in the Institute of Health Law. The class is entitled "White Collar Crime and Health Care." Phil welcomes friends and clients to attend a class and contribute. Call him if you are interested.

Ericka Adler was elected to a 3rd term on the Board of Directors of the Illinois Association of Healthcare Attorneys.

**HEALTHCARE: ILLINOIS SUPREME COURT
RULES IN FEE-SPLITTING CASE**

The Illinois Supreme Court recently filed its opinion in *Vine Street Clinic v. Health Link*, a case in which a physician partnership contended that a percentage fee arrangement between its physicians and a health care network violated the prohibition against fee splitting in the Illinois Medical Practice Act ("Act"). The arrangement in question required payment to the network of an administrative fee equal to 5% of the amount the physicians in the partnership charged for medical services provided to plan members. The court held that Section 22(a)(14) of the Act prohibits arrangements whereby a physician divides with anyone outside the physician's partnership, professional association or corporation a percentage of the fees earned for medical services. The Court held that while non-physicians, such as practice managers or billing agents, can receive a fee for services rendered, they cannot receive a percentage of a physician's revenue or its equivalent. This opinion was in agreement with the March 5, 2002 opinion letter issued by Illinois Attorney General Ryan, which concluded that a 5% administrative fee paid by providers to non-physician managers violated the Act and was therefore void under Illinois law.

The Court ruled that the Act did not prohibit the network from receiving a flat-fee for its administrative services based on the volume of claims processed for a physician during the prior year and the complexity of the claims submitted. The Court reasoned that, since a higher volume of claims or a more complicated specialty would result in a higher volume of work for the network, a fee arrangement that took these factors into account would fairly compensate it for its administrative services. In contrast, the Court noted that a flat-fee based on revenue volume would be impermissible. The Court's ruling partially reversed that of the appellate court, which held that the flat-fee payment also violated the Act.

VISIT OUR WEBSITE

We invite you to visit our newly re-designed and updated website:

www.kr-law.com

In addition to information about the Firm, the services we provide and our professional staff, you will find recent editions of our Firm's newsletter.

***CLIENT E-MAIL
UPDATE REQUEST***

We are in the process of updating our database and would like an accurate e-mail list for all of our clients. If there is any other additional information you would like to provide, you may list that also, i.e. cell phone. We are requesting that you provide your current e-mail address and any other additional information to us by one of the following methods:

E-mail.

Send an e-mail to info@kr-law.com. In the subject line, include the text "E-mail Information." In the message area, please include your name and company information. You may also list any additional e-mail addresses.

Fax.

You may also fax that same information to 847-982-1676.

Mail.

Mail information to: Lauren Hernandez, Kamensky Rubinstein Hochman & Delott, LLP, Suite 200, 7250 N. Cicero Ave., Lincolnwood, IL 60712-1776.

HEALTHCARE: ILLINOIS ATTORNEY GENERAL AND OIG ANNOUNCE TARGETED ENFORCEMENT AREAS FOR 2007-2008

The office of the Inspector General ("OIG") recently announced areas on which it plans to focus enforcement efforts over the next two years. The OIG is particularly interested in designated health services ("DHS") provided to Medicare beneficiaries by physicians in their offices. Areas of focus will include:

- Review of Medicare claims for physical and occupational therapy to determine whether the services were reasonable and medically necessary and adequately documented and certified by the ordering physician;
- Evaluate the appropriateness of Medicare services performed "incident to" the professional services of physicians. The OIG will identify "incident to" services to determine the extent to which the services met Medicare standards for medical necessity, documentation and quality of care;
- Review whether physicians properly code the place of service on claims for services provided in ambulatory surgery centers and hospital outpatient departments;
- Determine whether surgeons are improperly receiving separate payments for evaluation and management services during the global surgery period;
- Review the appropriateness of imaging services provided in physician offices. From 1999-2005, utilization of MRI, PET and CT scans grew, on average, 20% annually; and in 2005, Medicare paid over \$7 billion for these services;
- Review of medical records for durable medical equipment ("DME") items and supplies furnished to beneficiaries receiving home health services to determine whether the DME was reasonable and medically necessary;
- Review the relationships between billing companies and physicians and other Medicare providers using their services; and
- Review of Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and technical components.

On the state enforcement level, in a speech presented on October 4, 2006, Anne Murphy, senior counsel to Illinois Attorney General Lisa Madigan, noted some key Illinois enforcement initiatives, which included:

- Enforcement of the Consumer Fraud and Deceptive Practices Act by prosecuting providers who misrepresent or fail to disclose charges to health care consumers, fail to disclose conflicts of interest or financial incentives or issue misleading statements regarding treatment efficacy; and
- Investigation of complaints filed under the Illinois Whistleblower Reward and Protection Act and the Insurance Claims Fraud Protection Act, both of which have whistleblower provisions.

HEALTHCARE: 2007 RETIREMENT PLAN LIMITS

The IRS has announced the following cost of living adjustments for retirement plans for 2007. The following chart compares these 2006 and 2007 limits:

	2007	2006
Maximum Compensation Limit	\$225,000	\$220,000
Maximum annual addition dollar limit	\$ 45,000	\$ 44,000
Maximum annual addition percentage of compensation cap	100% of pay	100% of pay
Maximum 401(k) Contribution Dollar Limit	\$ 15,500	\$ 15,000
Maximum 401(k) "Catchup" Contribution*	\$ 5,000	\$ 5,000
Social Security Taxable Wage Base	\$ 97,500	\$ 94,200
Maximum Percentage for Permitted Disparity	5.7%	5.7%
Defined Benefit Plan Maximum Annual Benefit	\$180,000	\$175,000

* Plan Participants who are 50 or older in 2007 who make the maximum 401(k) contribution may also make a 401(k) "catchup" contribution of \$5,000 in calendar year 2007. The "catchup" contribution does not count as part of the maximum annual addition limit. Accordingly, in calendar year 2007, a participant in a 401(k) profit-sharing plan can make a 401(k) contribution of \$15,500, a 401(k) catchup contribution of \$5,000 and also receive employer contributions of up to \$29,500 for a total of \$50,000.

HEALTHCARE: PRACTICES MAY NOT CHARGE MEDICARE PATIENTS LATE FEES FOR ADMINISTRATIVE CHARGES

Providers should be aware that they are violating their Medicare Participation Agreement and could face sanctions for: (a) charging patients a late fee for unpaid co-pay and deductible balances; or (b) assessing an administrative fee to cover costs associated with running the medical practice.

Medicare laws restrict the amount that practices can charge patients when they bill Medicare as both participating and non-participating Medicare providers. According to CMS, providers who accept assignment agree to accept the Medicare fee schedule amounts as "the full charge for the service." Therefore, imposing penalties or late fees is interpreted by CMS as an impermissible increase to the charge for the Medicare-covered services that cannot be collected by the provider. Although the position being taken by CMS may be challenged down the line, smaller practices should follow CMS rules since they likely cannot afford to fight CMS on the issue.

To comply with the law but still protect the interest of a practice, another option may be to charge patients for the co-pay upfront. But even this approach can be a challenge for medical practices who may not know precisely what the patient owes until Medicare pays. Practices that are worried about lost co-pays should focus on patients that are not treated often by the practice since patients who are seen regularly in the practice and who pay their bills are likely to continue to do so.

Providers should also be careful not to charge any fees for retaining, maintaining or retrieving patient medical records. HIPAA forbids providers from charging patients for such services. Practices are allowed to charge patients for items that are clearly not included in the Medicare payment, such as a reasonable fee for making a copy of the patient's medical records, after hour prescription refills or writing letters to employers. However, practices would be better off charging patients when a request for a specific service is made, rather than instituting a blanket charge for all patients.

If you have any questions regarding the manner in which your practice operates and if you are in compliance with Medicare rules, please contact our office.

HEALTHCARE: IRS ISSUES FINAL RULES ON HEALTH SAVINGS ACCOUNTS

The IRS has issued final regulations that provide guidance on complying with the requirement that employer contribution to Health Savings Account ("HSA") be "comparable". These regulations apply to employer contributions to HSAs made on or after January 1, 2007.

Eligible employees may set up HSAs if they are covered under high-deductible health plans ("HDHP") and not covered under any other plans, [if they are subject to the exceptions they are not eligible]. Subject to certain statutory limits, eligible employees, employers, and others acting on behalf of eligible

individuals may make contributions to an HSA. Employer contributions are excludable from an employee's income and distributions for qualifying medical expenses are tax-free. Unlike other employer-provided benefits, HSAs are not subject to nondiscrimination rules restricting the amount of benefits provided to highly compensated employees. However, if an employer elects to fund HSAs for its employees, "comparable" contributions must be made to all "comparable" participating employees. In general, an employer must contribute the same amount or the same percentage of the HDHP deductible to all employees with the same HDHP coverage. Failure to comply with this requirement will result in the imposition of an excise tax.

The final regulations provide for the following:

- Family HDHP coverage may be subdivided into the following categories: self plus one; self plus two; and self plus three or more. In addition, an employer's contribution for the self plus two category must not be less than the contribution for the self plus one category, and the contribution for the self plus three category must not be less than for the self plus two category;
- Employees who are included in a unit covered by a collective bargaining agreement between employee representatives and one or more employers are not "comparable" employees, if health benefits were the subject of good faith bargaining. In other words, this comparable contribution rule does not apply to these employees; and
- Additional guidance is supplied on how employer HSA contributions are made through a Code § 125 cafeteria plan. Specifically, employer contributions to employees' HSAs are made through a cafeteria plan if under the written plan, the employees may elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution, regardless of whether an employee elects to contribute any amount to the HSA by salary reduction.

**INFORMATION & ARTICLES
IN THIS ISSUE**

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