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Healthcare/Litigation: Permissible Wage or Paid-Time-Off Deductions When Salaried Employees are Away From the Workplace; Liability for Failure to Disclose Adverse Information About Physician in Letters of Recommendation.

HEALTHCARE: NEW HOSPITAL DRG SYSTEM PROPOSED

The Center for Medicare Services (CMS) published a proposed rule in the April 25, 2006 Federal Register that would adopt a new method for calculating the values of inpatient DRGs to eliminate "the effects of systematic variation in hospital markups." The proposed rule will establish a severity-adjusted DRG system for calculating Medicare payments to hospitals. This final rule will be published in the fall of 2006 and would become effective during fiscal year 2007.

The new DRG system replaces the current DRG system with a new system that will differentiate patients with multiple comorbidities from other less complex patients. The system is slated for implementation in fiscal year 2008. For example, patients who have congestive heart failure with significant complications will be classified in a different DRG payment category than will patients with congestive heart failure without such complications. House Ways and Committee Chairman Bill Thomas recently sent a letter to Mark McClellan, current CMS Administrator, calling on the agency to implement both proposals in 2007. He cited the unnecessary payment fluctuation for providers between 2007 and 2008 that might result from the staggered implementation of changes.

HEALTHCARE: SOME OFFICE-BASED SURGERIES TO BE TRANSFERRED

CMS is considering allowing physicians to perform up to 450 specific office-based surgical procedures at ASC. The plan, which will commence in 2008, would make the procedures ASC-eligible but would cap the ASC's facility fee for such procedures so they would not exceed the Medicare Physician Fee Schedule's "non-facility practice expense payment."

Affected office-based services include the following: shaving and destruction of skin lesions, repair of superficial wounds, drain/inject joint bursa, treatment of metatarsal fracture, nasal sinus therapy, drainage of bladder, biopsy of cervix, nerve block injections, treatment of retinal lesions and repair of ear drum. CMS is focusing on excluding relatively inexpensive procedures, specifically those in the \$100 to \$200 range, from being shifted to ASCs.

Shifting such procedures to the ASC will provide greater convenience for patients undergoing multiple procedures by eliminating a separate trip to the physician's office. The change will also make it easier for physicians to schedule more of their patients at the ASC, potentially decrease the number of

unregulated office-based surgical suites and even making it easier for surgeons to comply with the Anti-Kickback Safe Harbors for ASCs.

Please call the health law department at the Firm, if you have any questions.

HEALTHCARE: UPDATE ON ATTORNEY GENERAL'S INVESTIGATION OF IMAGING CENTERS

In our last newsletter, we informed you that the Attorney General's Office of the State of Illinois had begun an investigation of imaging centers. Lease arrangements in which physicians lease equipment on a discounted basis are among the arrangements presently being reviewed. The Attorney General has now issued Subpoenas to both imaging centers and physicians who have leases at these centers. It is possible that the information which is acquired may be used for proposed legislation.

Commentators have indicated that it is generally believed that some physician referrals to imaging centers in which the physician has an ownership or lease arrangement may be unnecessary. In fact, the Medicare Payment Advisory Commission concluded that a variety of leasing, employment or compensation arrangements are either illegal or need to be further regulated to prevent "financial incentives that may improperly influence a physician's professional judgment."

California is considering requiring imaging centers or radiology offices, instead of a doctor, to bill insurers without paying a fee to the referring doctor. In Florida, a statute took effect in July targeting doctors who serve as medical directors at investor owned imaging clinics. Also in July, the Massachusetts Legislature directed the state inspector general to investigate improper referrals in the MRI market and suggest ways to combat abuse.

Based upon what seems to be occurring nationally, it is possible that legislation affecting these relationships (or litigation in the event that fraud or abuse are believed to exist) may occur within the next year or two. It is important that: (a) both imaging facilities and physicians referring patients to such facilities make sure that all referrals are proper and that true "at risk" relationships be created; and (2) patients are made aware of these financial relationships. If you would like to discuss these issues further or obtain guidance in structuring your own imaging relationships, please contact the Firm's health care department.

KRHD NOTES

Sherwin R. Rubinstein will be speaking at the Illinois Association Health Care Attorneys Annual Symposium on October 4, 2006 on the topic of "Avoiding Tax Pitfalls in Physician/Provider and Physician/Physicians Transactions."

Philip L. Pomerance will lecture on October 6, 2006 at the 18th Annual Health Law Seminar of the Tennessee Bar Association on "Crossing Borders Without Crossing Ethical Boundaries: The New World of Multi-Jurisdictional Law Practice" and will also speak on October 20th at an Illinois State Bar Association presentation and teleconference on the topic of "Protecting the Attorney-Client Privilege During Government Investigations of Corporate and Not-for-Profit Health Care Entities." Phil will also present a program at the Beard Group's 3rd Annual Physicians Agreement and Ventures Program in Chicago on "Ethics of the Multi-Jurisdictional Practice of Transactional Health Care Law."

Roger B. Mandel retired from the Firm on December 31, 2005 and is now of counsel.

Marvin Kamensky, Sherwin R. Rubinstein, Michael Erens and Miles Zaremski have all been selected as leading lawyers for 2007.

HEALTHCARE/LITIGATION: LIABILITY FOR FAILURE TO DISCLOSE ADVERSE INFORMATION ABOUT PHYSICIAN IN LETTERS OF RECOMMENDATION

A Washington hospital and professional liability insurer successfully sued a Louisiana hospital and two physicians for failure to disclose in their letters of recommendation that an anesthesiologist had been asked to leave the hospital and his practice because of his narcotic addiction. After receiving glowing letters of recommendation from the Louisiana hospital and physicians, the Washington hospital hired the anesthesiologist. Subsequently the hospital and the anesthesiologist were named as defendants in a malpractice suit brought by the family of a young woman who had suffered severe brain damage during anesthesia. During the malpractice suit, the woman's family discovered that the anesthesiologist had been asked to leave his former position in Louisiana because he had been diverting Demerol and had been found to be impaired while on the job. Because no formal action was taken against the anesthesiologist for his actions in Louisiana, his conduct was not reported to the National Physician Data Bank.

After settling this malpractice action for \$8.5 million, the Washington hospital and its professional liability insurer sued the Louisiana hospital and the two doctors who had provided favorable recommendations for the anesthesiologist. The Washington jury awarded damages in the amount of \$4 million for fraud and negligent misrepresentation. This is the first reported case in which a hospital considering the application of a physician for staff privileges has successfully sued another hospital for failure to disclose adverse information about the physician. This case sends an important message to hospitals and physicians about the necessity for truthfulness in response to requests for information by potential healthcare employers and will impact physician and hospital conduct in the future.

HEALTHCARE: COURT REJECTS PHYSICIAN'S RETALIATORY DISCHARGE CLAIM

The Eighth Circuit Court recently granted summary judgment in *Scott v. Missouri Valley Physicians* to partners of a Missouri physician who claimed that he had been terminated by his partnership because he was a whistleblower. The plaintiff was an at-will employee who was discharged by the partnership after complaining that the partnership's compensation formula violated the Stark law. The court ruled that the physician's actions did not constitute whistleblowing because he did not report the alleged violation to any outside agency, but merely complained to fellow Board members. The fact that the physician did not report the alleged wrongdoing to the proper authorities made the public policy exception to Missouri's employment-at-will doctrine inapplicable to his discharge. The reporting of possible Stark violations to alleged wrongdoers did not meet the whistleblower exception and was therefore not a retaliatory discharge.

The outcome would likely be the same in Illinois. Under the Whistleblower Act (740 ILCS 174/15), an employer is prohibited from retaliating against an employee who discloses information that the employee believes reveals a violation of federal or state law to a government or law enforcement agency. Disclosure only to private parties does not constitute "whistleblowing."

HEALTHCARE: CMS ANNOUNCES NEW RULES APPLYING TO DONATIONS OF ELECTRONIC HEALTH RECORDS AND E-PRESCRIBING TECHNOLOGY

On August 1, 2006, the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (DHHS) released final rules outlining two new exceptions under the Stark law and the corresponding safe harbors under the Anti-Kickback Statute applying to donations of technology for electronic prescribing and electronic health records (EHR). The rules will take effect on October 10, 2006.

The two new safe harbors set forth conditions which allow certain healthcare entities such as hospitals and group practices to donate: (1) electronic prescribing technology; and (2) donate EHR technology to health care providers without violating the Anti-Kickback Statute. To qualify for the e-prescribing technology safe harbor, certain criteria must be satisfied, including the following:

Technology that may be donated includes hardware, software, internet connectivity and training and support that are *necessary and used solely* to transmit and receive electronic prescription information;

- Covered donors and recipients are: (1) hospitals, to members of their medical staffs; (2) group practices, to prescribing healthcare professionals who are members of the group practice; and (3) prescription drug plan sponsors, to network pharmacies and prescribing healthcare professionals;
- Donors may not select recipients using any method that takes into account the volume or value of referrals from the recipients or other business generated between the parties;
- The donor must not limit or restrict the use or compatibility of the items/services with other e-prescribing systems or restrict the recipient's right to use the items/services for any patient;
- The recipient must not make the receipt of the technology a condition of doing business with the donor; and
- The donor does not have actual knowledge of, or act in reckless disregard of, the fact that the recipient already has obtained equivalent items or services. In other words, a donor must not provide technology that the donor is aware duplicates technology that the recipient already possesses.
- The EHR safe harbor requirements have features in common to the e-prescribing safe harbor but differ in the following ways:
 - Hardware is not covered;
 - There are only two categories of protected donors: (1) individuals/entities that provide covered services to Federal health care programs and (2) health plans.
 - Recipients must pay 15% of the donor's cost prior to receipt, and the donor must not finance this share of the provided cost; and
 - The items and services must not include staffing at the recipient's office and must not be used primarily to conduct business unrelated to clinical practice;

Failure to satisfy the safe harbor does not mean that an arrangement necessarily violates the statute but could entail risk depending on the facts and circumstances.

CMS simultaneously released two new exceptions to the Stark law covering the same areas. Because Stark prohibits a physician from making referrals for certain designated health services payable by Medicare to a health care entity with which the physician has a financial relationship, the donation of electronic e-prescribing technology or the software and training to create, maintain, transmit or receive electronic health records could be viewed as creating a financial relationship that would

be subject to Stark. For this reason, exceptions were adopted to permit certain entities, such as hospitals, to provide non-monetary assistance to physicians to encourage their use of new technology if certain criteria are satisfied. The criteria for the two new exceptions track the safe harbor requirements. Because the President's announced goal is for every American to have electronic health records by 2014, both the EHR exception and the EHR safe harbor sunset on December 31, 2013.

If you have any questions regarding the interpretation of these new rules, please contact the Firm's health law department.

HEALTHCARE: PROVISION OF MEDICAL RECORDS TO PATIENTS

Illinois law (235 ILCS 5/8-2003) requires all Illinois health care facilities and practitioners to provide copies of medical records upon written request by a patient or the patient's legal representative upon presentation of a valid signed authorization. In addition, every practitioner is required to permit the patient, the patient's practitioner or authorized attorney to examine and copy the patient's records. A request for examination and copying of medical records must be in writing and presented to the practitioner. Patient care records include, but are not limited to, those relating to the diagnosis, treatment, prognosis, history, notes, charts and pictures kept in connection with the patient's treatment.

A practitioner may request reimbursement at the time of copying for reasonable expenses, including the costs of independent copy services companies, not to exceed the amount determined in accordance with the following schedule:

FEE	2006
Handling Charge	\$22.28
Copy Pages 1-24	\$0.84 (per page)
Copy Pages 25-50	\$0.56
Copy Pages in excess of 50	\$0.28
Copies made from Microfiche or microfilm	\$1.39

These rates are automatically adjusted annually for inflation based on the percentage change in the consumer price index during the preceding 12 months. The adjusted rates are published on the Comptroller's official website on each January 31. A practitioner may charge additional fees for the reasonable cost of all duplication of record material (such as x-rays or pictures) that cannot routinely be copied on a standard commercial photocopy machine.

A request for patient records must be satisfied within 30 days after receiving a written request. If additional time is needed, then within 30 days after receiving a request, a practitioner must provide the requesting party with a written statement detailing the reasons for the delay and the date by which the information will be provided. In no event may the information be provided later than 60 days after receiving a request. A practitioner who fails to comply with these time limits will be required to pay all expenses and reasonable attorney fees incurred in connection with any court ordered enforcement of the law.

HEALTHCARE: APPELLATE COURT UPHOLDS REGULATION LIMITING PRACTICE OF NURSE ANESTHETISTS IN OFFICES

The Illinois 1st District Appellate Court recently upheld a 2001 state regulation that allows nurse anesthetists to provide anesthesia in a physician's office only if the physician has ongoing training in anesthesia. In *Pollacheck v. The Department of Professional Regulation* a nurse anesthetist sought an injunction prohibiting enforcement of the regulation by the Illinois Department of Financial and Professional Regulation (IDFPR), arguing that the regulation was inconsistent with the Nursing Act. The trial court prevented the IDFPR from enforcing the regulation, ruling that the Nursing Act did not expressly provide for regulations requiring licensed physicians to undergo anesthesia training when they worked with nurse anesthetists in their offices. The Appellate Court reversed the lower court's decision, holding that the regulation is valid and consistent with statutory language. The Court found that the Nursing Act gives the IDFPR authority to make rules to implement the purposes of the Nursing Act and the enabling language applies both to registered nurses and to advanced practice nurses, such as anesthetists. Furthermore, the Nursing Act strongly suggests that physicians must have some training in anesthesia, since physicians must enter into collaborative agreements with the nurse anesthetists who provide anesthesia in their offices. The Court stated that the anesthetist failed to show that the regulation created an economic hardship.

The Illinois Society of Nurse Anesthetists is concerned that the regulation could limit the ability of nurse anesthetists to provide office anesthesia because some physicians are unwilling to undergo the additional training in anesthesia. Physicians who currently use nurse anesthetists in their practice but do not have the necessary training may contact the Firm to discuss available options.

LITIGATION: PERMISSIBLE WAGE OR PAID-TIME-OFF DEDUCTIONS WHEN SALARIED EMPLOYEES ARE AWAY FROM THE WORKPLACE

Employers often ask whether they must pay salaried employees when they are away from the workplace for personal reasons or due to illness or accident. The answer depends on whether the employee is considered "exempt" or "non-exempt" under the Fair Labor Standards Act (FLSA). Salaried employees who meet specified requirements of FLSA are classified as "exempt" employees. An employer is not required to pay exempt employees overtime wages when they work more than 40 hours per week. To meet the FLSA definition of an exempt employee, the following three tests must be met: (1) the "salary basis" test, requiring that an employee must be paid a regular wage each period that is "not subject to reduction based on variations in the quality or the quantity of work performed," except as permitted under law; (2) the "exempt duty" test, requiring that an employee must be classified as either an executive, an administrator, a learned or creative professional or a computer professional; and (3) the "salary level" test, requiring that an employee must earn at least \$455.00 in any week. Under the Illinois Minimum Wage Law, there are additional qualifying positions: vehicle salespersons, certain government employees and employees of not-for-profit educational or residential child care facilities.

Under FLSA, there are seven circumstances under which employers may make deductions in the pay of exempt workers under the "no pay docking rule:"

- Absences of one full day or more for personal reasons (partial days may not be deducted);
- Absences of one full day or more for sickness or disability if the deductions are made pursuant to a workplace's bona fide plan, policy or practice. For example, if the policy allows 10 days off for sickness or disability and the employee takes an additional day off, then pay for this additional day may be deducted;
- Offsets for payments for jury fees, witness fees or military duty;
- Penalties imposed in good faith for violation of major safety rules;
- Disciplinary suspensions imposed in good faith of one or more full days for violations of workplace conduct rules;
- Unpaid Family and Medical Leave; and
- Proportionate salary deducted for days worked during an employee's first and last weeks of employment.

Deductions from an exempt employee's pay for less than a full day's absence due to either personal or health-related reasons are not permitted under FLSA regulations. For example, if an employee takes off a day and a half for personal reasons, wage deductions may be made for only one day's absence.

However, Illinois courts have ruled that reducing Paid-Time-Off ("PTO") (instead of weekly wages) for absences due to personal reasons, even when the employee misses less than a full day of work, is permissible and will not jeopardize the exempt status of an employee.

When an employer has a bona fide benefit plan in place, it is permissible to substitute or reduce accrued PTO for the time an exempt employee is absent from work due to illness or disability, even when less than a full day, without adversely affecting the employee's exempt status, as long as the employee still receives as payment an amount equal to the employee's guaranteed salary under the benefit plan. For example, if an exempt employee takes a half-day off for illness, then this half-day off may be deducted from accrued PTO, although an employer may not deduct this partial day from the employee's salary.

Non-exempt, hourly employees only have to be compensated for time actually worked. For example, if the workplace is closed by the employer and hourly employee cannot work as a result, the time during which the workplace is closed does not count as hours worked and hourly pay may be docked. Alternatively, employees may be allowed to take leave to cover the hours off. If an employer does not wish to treat exempt and hourly employees differently, an option is to adopt a policy that provides full pay to all employees in the event of particular circumstances, such as closure for inclement weather.

If you have any questions regarding the benefit issues discussed in this article, please contact the Firm's corporate department.

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