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### IN THIS ISSUE

**Insurance:**

Medical Malpractice: Minimizing Risk

**Stark:**

Proposed Stark Changes: Update

**Health Care:**

Tax-Exempt Hospitals Soon To Report Physician Ventures

**Health Care:**

Medicare Seriously Tightens Rules Concerning Qualifications for Individuals Who Assist Physicians in Delivering Physical and Occupational Therapy in the Office Setting

**Health Care:**

Professional Regulation: Update

#### INSURANCE: Medical Malpractice: Minimizing Risk

Most providers are concerned with the threat of malpractice, which can take a financial toll on a practice as well as on his or her personal assets. Malpractice claims can result in a significant increase in malpractice premiums or termination of malpractice coverage. Some malpractice cases can even result in an investigation of a provider's professional license.

There are some simple steps that all providers can take to minimize the risks associated with malpractice claims, including the following:

Make sure your records are complete and accurately reflect all services rendered and information provided to the patient.

Make certain your records are legible. Some hospitals and medical groups provide seminars on quick (yet legible) and writing. Consider dictating your charts and then have them transcribed.

3. Document patient complaints and attempts at resolution.
4. Use standard medical abbreviations and follow JCAHO guidelines.
5. Adequately disclose all known, reasonable risks to patients prior to performing medical procedures.
6. Manage patient expectations; do not promise more than what can reasonably be achieved.
7. Remember that ancillary service providers (such as nurses, physician assistants and medical technicians), even if licensed on their own, work under your supervision. Provide proper supervision in all instances.

8. Properly screen applicants before hiring, verify credentials and monitor documentation of ancillary services providers. Know when and how to discharge employees whose professional conduct may be putting you at risk.

9. Do not engage in medical procedures or treatment for which you are not properly trained, and know when to ask for assistance. Do not discourage second opinions.

10. Improve communication skills with patients to lessen the chance of a lawsuit by:

- Conveying medical information in a simple way, using easy to understand language, diagrams or sketches, as applicable.
- Make certain your patients feel fully informed about their treatment and outcome potentials.
- Show concern, understanding and empathy for a patient's situation. Maintain good follow-up procedures (i.e., return calls promptly; keep the patient informed of his or her progress of care; establish good relationships with patient's relatives).
- Say you are "sorry." A nationwide advocacy group called "The Sorry Works! Coalition" advocates that doctors should be allowed to apologize for medical errors, in the hope the words "I'm sorry" will lead to fewer lawsuits and lower settlements. Illinois has a so-called "sorry law," which provides that upon meeting specific guidelines an expression of grief, apology, or explanation provided by a health care provider to a patient shall not be admissible as evidence in any malpractice action.

## **Continued from previous column--**

Upon receiving notice of a lawsuit, you must promptly notify your malpractice carrier. It is likely your carrier has provided you with specific protocols to follow in the event you are involved in a suit. It is important you follow the insurer's direction, as most policies require you do so as a condition of coverage. Your insurance carrier will hire a lawyer on your behalf. In the event it appears a malpractice plaintiff may receive an amount in excess of his or her malpractice policy limits (commonly referred to as an "excess verdict"), it is critical to secure personal representation early in the litigation. In an excess verdict scenario, the interests of the malpractice insurer and the physician may begin to diverge, with the former only responsible for the policy limits, and the physician responsible for any excess amount. The Firm has extensive experience representing physicians in excess verdict cases and we are always available to discuss these issues with you.

## **MALPRACTICE CARRIER HEARINGS**

A physician may be required to discuss the basis for the malpractice claim, discuss the ultimate outcome with his or her malpractice insurer and "defend" his or her actions. Often, these "hearings" result in an increase in his or her malpractice premiums. The Firm is experienced in assisting physicians to prepare for the hearing process.

## **PROTECTING PERSONAL ASSETS**

In order to protect your personal assets, all providers should take steps to make their assets as "judgment proof" as possible. Please contact the Firm to discuss this specialized estate planning.

## **REGULATORY AGENCIES/NATIONAL PRACTITIONER DATABANK**

Under the Illinois Medical Practice Act (the "MPA"), a physician is obligated to report a settlement or judgment in a medical malpractice action to the Illinois Department of Financial and Professional Regulation (the "IDFPR"). The MPA also requires insurance carriers to report the same. After receiving a report from an insurance carrier, the IDFPR will notify a physician of the report and request detailed information regarding the claim and treatment. From this information, the IDFPR will decide whether to pursue disciplinary action against the physician. Generally, a physician's malpractice attorney will not guide him or her through the process of an IDFPR investigation. It is critical the physician contact his or her own attorney, who is specialized in actions before the IDFPR Board.

The National Practitioner Databank ("NPDB") was established by the Health Care Quality Improvement Act of 1986 (the "Act"). Under the Act, an entity or insurance company that makes a payment of a settlement or judgment on behalf of a physician for a professional malpractice claim must report the payment to the NPDB and to the appropriate state licensing board(s). A report to the NPDB can have significant repercussions and should not be taken lightly. It may impact a decision on a physician's staff privileges or employment relationship. As state licensing board(s) have access to the NPDB, a report made to the NPDB may also impact potential licensure decisions and could trigger an IDFPR investigation. Although it is recognized that lawsuits are often settled for reasons other than the negligence of a practitioner, the

requirement that all settlements or payments of judgment must be reported to the NPDB flags a practitioner for further scrutiny. When considering whether to settle a matter or proceed to trial, a practitioner should consider how a potential report to the NPDB could impact professional and employment relationships, as well as licensure. The Firm can assist providers in actions before both the IDFPR and NPDB. Our attorneys are nationally recognized for their representation of physicians related to licensing and credentialing issues. Please contact us if you require assistance.

## **STARK:**

### **PROPOSED STARK CHANGES: UPDATED**

Our last newsletter detailed significant Stark Law changes and it appears the Center for Medicare and Medicaid Services ("CMS") is not done yet. On April 14, 2008, CMS proposed more changes to Stark (the full text of the proposals can be found on pages 577-621 at: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-P.pdf>). None of these proposals are in effect. CMS currently is soliciting comments on whether these changes should be adopted. If you would like to comment on a proposed change, please contact us. We can provide you with more detailed information on each proposal, as well as guide you through the comment process.

**1. Stand in the Shoes.** As noted in our prior newsletter, CMS adopted a provision whereby physicians would "stand in the shoes" of their physician organizations. CMS also proposed a similar rule under which a healthcare entity would "stand in the shoes" of any entity it owns or controls. Both of these provisions may turn an otherwise "indirect" financial relationship into a "direct" financial relationship, altering the type of Stark referral exceptions available to comply with the regulation. CMS is now proposing revisions to both these "stand in the shoes" provisions, as follows:

- Physicians would not be deemed to stand in the shoes of their physician organization if the compensation arrangement is between the physician organization and the physician satisfies one of these Stark exceptions: employment relationship; personal service or fair market value compensation. Physician owners and investors, however, will still stand in the shoes of their physician organizations.
- CMS is seeking comments on whether physician owners should stand in the shoes of their physician organization when their interest is nominal and their compensation arrangement with the physician organization satisfies the Stark exceptions for personal services, employment relationships or fair market value compensation.
- CMS is seeking comments on whether meeting other Stark exceptions should prohibit application of the stand in the shoes provision.
- CMS is seeking comments on ways in which it can ensure that the full range of potentially abusive arrangements between DHS entities and physician organizations are appropriately addressed in situations where physicians do not stand in the shoes of their physician organizations.

**Continued from previous column ---**

- An entity providing DHS would stand in the shoes only of an organization in which it has 100% ownership interest.
- CMS is seeking comments on whether it should consider a DHS entity to stand in the shoes of an organization in which the DHS entity holds less than 100% interest.
- CMS is seeking comments on whether it should consider a DHS entity to stand in the shoes of an organization in which it controls, as well as how to define “control.”
- The definitions of “physician” and “physician organization” would be changed to clarify that a physician and a professional corporation of which he or she is a sole owner will always be treated as “one” for the purpose of applying any Stark regulations.

**2. Period of Disallowance.** CMS is proposing to define the period of time, after violating Stark, when physicians will be disallowed from referring patients for DHS payable under a federal healthcare program (the “Period of Disallowance” or “POD”). The proposals are as follows:

- Physician was non-compliant for reasons unrelated to compensation (i.e. the agreement was not in writing). The POD will begin on the date the non-compliance began (i.e. the effective date of the agreement) and end on the date the arrangement was brought into compliance (i.e. reduced to writing).

- Physician was non-compliant for reasons related to compensation (i.e. physician was paid more than fair market value for services; or physician was paid less than fair market value for space rental): The POD will begin on the date the non-compliance began (i.e. when physician began receiving payment for services; when physician began paying rent) and end on the date the physician returns the excess compensation, plus interest (or in the case of space rental, the physician repays any fair market value shortfall) and the agreement otherwise meets all other requirements of the Stark exception.

- Physician was non-compliant for reasons related to compensation, but NOT involving excess payments or shortfalls (i.e. physician was compensated based on the volume or value of referrals) or the physician did not return any excess compensation or pay any shortfall prior to the agreement ending. CMS has made no proposed changes and intends to deal with these issues on a case-by-case basis.

- CMS will NOT except parties that were unaware of any non-compliance with the law.

- CMS may propose future regulations preventing physicians from relying for a period of time on a Stark exception with which they were previously non-compliant (i.e. if a physician previously paid less than fair market value under a space lease, the physician would be barred from relying on the Stark space lease exception for any lease transaction for a certain period of time).

**3. Gainsharing.** Gainsharing typically refers to an arrangement under which a hospital gives physicians a share of the reduction in the hospital’s costs (that is, the hospital’s cost

savings) attributable in part to the physician’s efforts. Gainsharing arrangements implicate Stark if physicians make referrals to a hospital with which they have a gainsharing agreement. CMS is soliciting comments on the following issues related to gainsharing: (1) whether certain gainsharing services or arrangements should be disallowed under Stark; (2) should there be a gainsharing exception to Stark; and (3) what types of safeguards should be in place to ensure gainsharing arrangements are not abusive.

**4. Physician Owned Implant/Medical Device Companies.**

CMS recognizes that the number of physician investors in implant/medical device companies has increased. It is concerned that these physician-investors are in a position to benefit financially from referrals to hospitals that, in turn, purchase products manufactured or distributed by a company in which the physician has an interest. Although CMS made no specific proposal at this time, it is soliciting comments on the following issues: (1) should Stark specifically address the issue of physician ownership in implant/medical device companies, or are current Stark regulations related to indirect ownership sufficient to analyze the problem; (2) is it more proper to address those issues via the Federal Anti-Kickback Statute or Federal False Claims Statute; (3) to what degree are these arrangements potentially abusive; and (4) what actions can CMS take to cure any perceived problems with these types of ownership arrangements.

**HEALTH CARE: TAX-EXEMPT HOSPITALS SOON TO REPORT PHYSICIAN VENTURES**

As of the 2008 tax year (returns filed in 2009), a change in IRS Form 990 and Schedule H for tax-exempt hospitals will require disclosure of all a hospital’s management companies and joint ventures where physicians hold an aggregate five percent (5%) or greater ownership interest. Hospitals will need to report: (1) name of the entity; (2) description of the primary activities of the entity; (3) percent of ownership and profit attributed to the hospital; (4) percent of ownership and profit attributed to physicians; and (5) percent of ownership and profit attributed to officers, directors, trustees or key employees.

While this information will only be furnished to the IRS, we can reasonably conclude that it may be made available to other federal regulatory agencies, including the Center for Medicare and Medicaid Services and the Office of the Inspector General. To this end, these IRS revisions should serve as a reminder to ensure that your practice and business ventures fully comply with all federal and state regulations. Should you have any questions or would like us to assess your current business structures, please do not hesitate to contact our office.

**HEALTHCARE: MEDICARE SERIOUSLY TIGHTENS RULES CONCERNING QUALIFICATIONS FOR INDIVIDUALS WHO ASSIST PHYSICIANS IN DELIVERING PHYSICAL AND OCCUPATIONAL THERAPY IN THE OFFICE SETTING**

Last year, Medicare implemented a policy prohibiting a physician from serving as a “supervisor” for a physical therapy assistant. Thus, a physician who employed or contracted with a physical therapy assistant to implement a therapy plan under the physician’s direction, would have to contract or arrange for supervision of the assistant by a licensed physical therapist.

**Continued from previous column ---**

Until recently, it was long standing practice that a physician who was physically present in the office suite could use unlicensed personnel to implement the therapy plan developed by the physician for a patient. The physician, however, remained responsible for the evaluation and re-evaluation of any patient treated in a therapeutic program that was implemented by the unlicensed personnel that the physician was supervising directly.

Recently, Medicare implemented a policy change that requires all physical and occupational therapy be performed by "Qualified Personnel." Qualified Personnel do not have to possess a state license in either physical or occupational therapy, but essentially must be able to demonstrate equivalent training. Since licensing laws for these allied health professionals are gradually becoming more restrictive by requiring a Master's degree or Doctoral degree as a minimal requirement for licensure, this equivalent training requirement for "Qualified Personnel" will be virtually impossible to meet. Thus, the only way to bill for physical or occupational therapy services provided by individuals who do not meet the criteria for "Qualified Personnel" is for the physician to be physically present in the therapy room when the therapy is being provided and personally supervise the therapy. If you are concerned how this change may impact your practice, please contact us.

**HEALTH CARE: PROFESSIONAL REGULATION UPDATE**

The Illinois Department of Financial and Professional Regulation has proposed to add a regulation under the Medical Practice Act relating to the use of certain laser or light treatment systems. If adopted, the regulation would classify the use of light emitting devices, such as lasers, intense pulsed-light, radio frequency and medical microwave devices used for the treatment of dermatologic conditions or cosmetic procedures as the "practice of medicine." These types of services will need to be performed personally by a licensed physician, or delegated to a nurse or other persons by a licensed physician. Services performed by a non-physician would need to be: (1) performed under the on-site supervision of a physician; and (2) performed only after a physician's initial examination of the patient and completion of a patient treatment plan. In addition, a physician

will only be able to delegate the performance of these services to persons receiving documented training and education on the safe and effective use of each system, and the physician must be on-site and maintain ultimate responsibility for all services performed.

This proposed amendment is not intended to prevent a licensed dentist, podiatrist, advanced practice nurse or physician assistant from performing any services allowed under their respective practice acts. We will keep you posted on any further developments.

**KRHD NOTES**

**Ericka Adler and Christina Kuta** both spoke about "Minimizing Malpractice Risks" at St. Mary's Hospital on March 13, 2008.

**Ericka Adler** gave a speech on "Negotiating your First Employment Agreement" at UIC on March 19, 2008.

**Richard P. Sora** will be joining the Firm as a Partner effective June 1, 2008.

**INFORMATION & ARTICLES IN THIS ISSUE**

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