

# KAMENSKY RUBINSTEIN HOCHMAN & DELOTT, LLP

Summer 2009 LAW UPDATE

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### MEDICAL RECORDS:

#### Be Careful What You Charge Patients for Medical Records

A November 2008 decision of the Illinois Appellate Court held that automatically charging a flat “handling fee” to copy medical records is improper under Part 20 of the Illinois Code of Civil Procedure, which addresses medical record fees. Currently, Illinois law states that a provider may be reimbursed a handling charge not to exceed \$20.00 (adjusted each year for inflation and set at \$23.80 for 2009), in addition to a maximum per-page fee. The court determined that automatically charging every patient a flat \$20.00 fee is not permissible, unless such a charge reflects the reasonable cost of providing the records.

Although this recent decision marks the first time an Illinois court has questioned the validity of a flat-fee handling charge for medical records, this practice has been prohibited in all states under the Health Insurance Portability and Accountability Act (“HIPAA”). HIPAA specifically allows providers to charge a reasonable, cost-based fee for medical records (i.e. labor and supply costs of copying and postage), with a state’s per-page copy charge considered presumptively “reasonable.” A provider may not, however, charge a “handling” fee for processing or retrieving medical records.

To be compliant with both federal and Illinois law a provider may only charge the per-page copying fee within the limits imposed by Illinois statute. Any flat-fee charges or charges related to retrieving or processing medical record requests are not permissible.

Should you have any questions regarding your current medical record fee request policies or fees, please contact us. Our attorneys are happy to review your current procedures and assist you in complying with federal and state law.

#### HIPAA Impacted by the Economic Stimulus Act

Rarely mentioned in political discussions of the American Recovery and Reinvestment Act of 2009 (more commonly referred to as the Economic Stimulus Act) (the “Act”) is a provision known as the “Health Information Technology for Economic and Clinical Health Act” (“HITECH”). Beginning February 2010, HITECH will dramatically impact current HIPAA regulations, as well as health professionals and their practices.

**1. Security Breaches:** With the exception of incidental disclosures, providers will be required to notify patients of any unauthorized access or breach of their Personal Health Information (“PHI”) within 60 days after the breach. If a breach affects more than 500 patients, the provider must notify the Department of Health and Human Services (“HHS”), which will report the name of the provider on its website. If a breach affects more than 500 people located in the same geographic area, the provider must also contact that local media market. A provider’s business associates must inform the provider of any unauthorized breach, and the provider must treat such breaches in a similar manner.

**2. Penalties:** Under HITECH, civil monetary penalties will increase, and such penalties will be mandatory for HIPAA violations attributable to “willful neglect.” Previously, HIPAA enforcement bodies had discretion on whether to impose financial penalties. HITECH further expands civil monetary penalties and criminal liability to business associates, and allows for criminal penalties to be applied to any individual or employee of a provider who obtains unauthorized PHI.

**3. Right of Action:** HITECH creates a private right of action for HIPAA violations. HITECH also allows a state to file suit on behalf of a patient whose HIPAA rights are violated, and patients may recover civil damages, costs and attorneys’ fees.

**4. Electronic Health Records:** HITECH changes current HIPAA rules and requires that a record of disclosures for treatment, payment and healthcare operations be kept for PHI maintained in an Electronic Health Records (“EHR”) system. The effective date of this requirement depends upon when the provider began using the EHR system, but will not be earlier than 2011. HITECH allows patients to elect to receive their PHI via electronic format if the provider maintains an EHR system. The patient can also designate an individual to receive the electronic transmission and cannot be charged more than labor cost for completing the request.

HITECH provides financial incentives for providers to establish EHR systems. Although providers are not required to adopt an EHR system, those who fail to do so by 2015 may face decreased Medicare reimbursement rates, unless they can show “significant hardship.”

**5. Right to Restrict Information:** HITECH allows patients to request that certain information not be released to the patient’s health

plan. Information unrelated to treatment and services a patient pays for out-of-pocket cannot be disclosed if the patient objects. Any information falling outside this category may still be disclosed to health plans within the confines of all other applicable HIPAA regulations.

**6. Sale of PHI:** Providers may no longer accept remuneration in exchange for HIPAA-compliant PHI disclosures, unless such disclosures are made for one of the following purposes:

- Public health activity;
- Research activity and the charge relates to the cost of preparation and transmittal;
- Treatment of the patient;
- Sale or merger of all or part of the provider;
- It is a necessary function of a business associate and is pursuant to a valid business associate agreement;
- To provide a copy of PHI to the patient; or
- Other activity as directed by HHS.

Given these changes in HIPAA regulations and enforcement, it is critical to ensure that your HIPAA policies and business associate agreements are in full regulatory compliance. Please contact our attorneys if you would like us to review your HIPAA compliance

### **MEDICAID/MEDICARE:**

#### **Changes in CPAP Billing**

In March 2008, Medicare issued regulations that would allow payments for unattended, home-based sleep studies used to diagnose sleep apnea. In response to those regulations, CMS expressed concern that many physicians who are involved in the supply of CPAP equipment would have an incentive to increase home sleep study referrals, in an effort to profit from the provision of CPAP equipment. To this end, CMS recently published new regulations addressing these concerns.

As of January 1, 2009, Medicare prohibits payment to the supplier of a CPAP device if the supplier or its affiliate (i.e., a person or organization that is related to another through ownership or compensation arrangement) is directly or indirectly the provider of the sleep test used to diagnosis the sleep apnea. This prohibition, however, does **not** apply when the sleep test used to diagnosis the sleep apnea is an "Attended, Facility-Based Polysomnogram." An Attended, Facility-Based Polysomnogram includes:

[A] comprehensive diagnostic sleep test including at least electroencephalography, electro-oculography, electromyography, heart rate or electrocardiography, airflow, breathing effort, and arterial oxygen saturation furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed.

In practice, the prohibition on payments to CPAP suppliers will not apply as long as the sleep test was conducted outside the patient's home and in the presence of a technologist or provider monitoring the testing.

#### **Changes in Medicaid Billing**

Beginning March 1, 2009, all providers submitting claims to Medicaid via the 837 and Direct Data Entry formats will need to designate the "Pay-to-Provider Payee" by National Provider Identifier ("NPI") number and **not** by the one-digit payee code, as previously required. Providers using paper claim forms, however, will continue to designate payees by the payee code. For information on this change, view the Illinois Department of Healthcare and Family Services' Information Notice at <http://www.hfs.illinois.gov/assets/101408npi.pdf>. If you need any information on obtaining an NPI number, please contact us.

### **STARK:**

#### **Providing Durable Medical Equipment ("DME") Under Stark**

As physicians become more involved in the provision of ancillary services, many also want to be able to provide DME to their patients. Under the Stark Law, DME is a designated health service. A physician who both orders DME and provides that DME is making a self-referral, which triggers Stark and necessitates meeting a Stark exception.

The only exception available is for In-Office Ancillary Services ("In-Office Exception"). Under Stark III regulations, the following types of DME can be provided pursuant to the In-Office Exception: canes; crutches; walkers; blood glucose monitors; and folding manual wheelchairs. All other DME, including C-PAP equipment, cannot be referred under the In-Office Exception.

For a physician to both order and provide DME that does not qualify for the In-Office Exception, the physician must: (1) enroll with Medicare as a DME provider; **and** (2) personally provide the DME. In order to personally provide the DME a physician must minimally:

- Personally fit the DME item for the patient;
- Provide necessary information and instructions concerning use of the DME;
- Advise the patient that he or she may either rent or purchase inexpensive or routinely purchased DME;
- Explain the purchase options for capped rental DME;
- Explain all warranties;
- As needed, deliver the DME to the patient at his or her residence; and
- Explain to the patient at the time of deliver how to contact the physician in his or her capacity as a DME supplier.

CMS notes, however, that it is highly unlikely that a referring physician would meet these criteria for personally performed services when dispensing DME.

Physicians can avoid having to personally perform the provision of DME and enroll as a DME supplier if they refrain from supplying DME to their Medicare and Medicaid patients. Providing DME strictly to non-federal healthcare patients falls outside the scope of the Stark law and does not present a problem under similar Illinois self-referral provisions.

### **NEW ANTI-MARKUP REGULATIONS: Is Your Practice Billing More Than it Should?**

As discussed in prior Newsletters, the Centers for Medicare and Medicaid Services ("CMS") has proposed anti-markup regulations over the past year related to diagnostic testing procedures payable under Medicare and Medicaid. The long-anticipated, final anti-markup regulations were published in the 2009 Physician Fee Schedule and are now in effect.

#### **I. WHAT IS ANTI-MARK UP?**

The Anti-Markup Rule details when a provider is prevented from "marking up" (i.e., charging more than the cost) the Technical Component ("TC") and the Professional Component ("PC") of providing the test. Whether billing separately for the TC or PC or billing globally, if a provider is prevented from marking-up the TC and/or PC, then payment for the TC and/or PC to that provider is limited to lowest of:

- (1) The performing supplier's (i.e., physician who performed the PC or supervised the TC) net charge to the billing provider;
- (2) The billing provider's actual charge; or
- (3) The physician fee schedule amount.

Typically, the performing supplier's net charge is the lowest amount.

## II. WHEN IS MARK-UP PROHIBITED?

Two separate, alternative tests are used to determine whether markup is prohibited: (1) the "substantially all services" test; and (2) the "site of service" test. If a provider satisfies either of these tests, then the Anti-Markup Rule does not apply.

### A. Substantially all Services Test

If the physician performing the PC performs at least 75% of his or her professional services solely for the billing provider, then markup of the PC **is not** prohibited.

Similarly, if the physician supervising the TC performs at least 75% of his or her professional services solely for the billing provider, then markup of the PC **is not** prohibited. The physician supervising the TC need not be the radiologist – just an employee or contractor who spends 75% of his or her time with the ordering physician.

To meet the 75% threshold, the performing physician must: (1) have furnished at least 75% of all his or her professional services through the billing physician or other supplier for a period of 12 months prior to and including the month in which the services was performed; or (2) be expected to furnish at least 75% of all of his or her professional services through the billing physician during the following 12 months and including the month the service is performed.

### B. Site of Service Test

The site of service test requires:

- (1) The physician performing the PC or supervising the TC is an owner, employee or independent contractor of the billing provider; and
- (2) The PC is performed, and the TC is performed and supervised, in the office of the billing provider.

The billing provider's office is defined as any medical office space where the ordering physician regularly furnishes patient care, including space where diagnostic testing is furnished if it is in the same building (structure or structures sharing the same street address) where the ordering physician regularly furnishes patient care. With respect to multiple physician group offices, if the ordering physician only performs services in office A, then performance of the PC at office B will not be considered the "office of the ordering physician."

The site of service test is not met, however, if the TC or PC is performed in a centralized building that is not located in the same building where the ordering physician regularly performs services. As a result, many centralized building arrangements that meet Stark requirements will not meet the site of service test.

We will continue to review arrangements where the Anti-Markup Rule may be at issue. You are encouraged to contact us with any concerns.

## LEGISLATIVE UPDATE, ESTATE PLANNING CHANGES AND PROPOSALS:

A. Washington Report. Under current law, the federal estate tax exemption is \$3,500,000 for a decedent who dies in 2009. The federal estate tax will be repealed in 2010, but reinstated in 2011 with a \$1,000,000 exemption. Since these changes were enacted in 2001, there has been continued speculation that the estate and gift tax laws would be further modified before 2010.

In January of this year, H.R. 336 was introduced by Representative Earl Pomeroy (D-ND) in an attempt to resolve the current uncertainty. Representative Pomeroy's bill would keep

the federal estate tax exemption of \$3,500,000; keep the top estate tax rate at 45%; and add a 5% surtax for estates over \$10,000,000.

H.R. 436 would also eliminate any discounts in valuing intra-family transfers. Although there will continue to be many benefits to a family limited partnership from an asset protection point of view, the estate and gift tax benefits will be reduced if this provision of the bill becomes law.

In March 26, 2009, Senator Max Baucus (D-MT), chairman of the Senate Finance Committee, introduced the Taxpayer Certainty and Relief Act of 2009 (S. 722). As with Representative Pomeroy's bill, S. 722 would also make permanent the current \$3,500,000 exemption and keep the top estate tax rate at 45%. These changes are consistent with budget proposals by the Obama administration.

Under S 722, the exemption amount would be indexed for inflation starting in 2011. This spouse's exemption, in addition to the surviving spouse's own estate tax exemption. S. 722 would re-unify the federal gift tax and estate tax by providing a single exclusion of \$3,500,000.

### B. Illinois Legislation

Prior to 2009, the state exemption for the Illinois estate tax was the same as for federal estate taxes. In 2009, the exemption for Illinois estate tax remained at the 2008 level of \$2,000,000, while the federal exemption increased to \$3,500,000. This marks the first time since the Illinois estate tax was enacted that the federal and Illinois estate tax exemption amounts are not coordinated.

C. Illinois Estate State Tax Rate is 16%. In estate plans with marital and residuary trusts, the residuary trust is usually funded to the maximum federal exemption, currently \$3,500,000. Because the federal and Illinois estate tax exemptions are no longer identical, allocating more than the Illinois exemption amount to the residuary trust could result in an Illinois estate tax at the death of the first spouse. Accordingly, it may be appropriate to limit the allocation of assets to your residuary trust to the maximum amount that will be free of both federal and state estate taxes at the death of the first spouse. If you would like to review your estate planning or discuss this issue, please contact us.

### D. Gift Provisions

In 2009, the annual gift exclusion increased to \$13,000 per donee (and \$26,000 per donee for gifts by a husband and wife). Annual exclusion gifts can be made in many forms – outright to adults, to custodial accounts for minors or to properly structured irrevocable trusts which qualify not only the annual exclusion but which may also be exempt from generation skipping taxes.

### E. Retirement Benefits and Required Minimum Distribution

The Worker and Retiree Recovery Act of 2008 eliminates required minimum distributions from IRAs and defined contributions plans (e.g., profit-sharing plans, 401(k) plans and defined contribution or money purchase pension plans) for 2009. This change does not apply to defined benefit pension plans, and participants in those plans must still receive the minimum distribution required for 2009 by December 31, 2009 (or in the case of a participant who reaches age 70-1/2 in 2009, by April 1, 2010).

## **KRHD NOTES**

**Christina M. Kuta** was recently selected to the Publication Committee for the Illinois Association of Healthcare Attorneys.

**Ericka L. Adler** was voted a Rising Star in Health Law in the 2009 Illinois Super Lawyers Publication.

**Marvin Kamensky, Michael Erens and Philip Pomerance** were listed as Super Lawyers the 2009 Illinois Super Lawyers Publication.

## **INFORMATION & ARTICLES IN THIS ISSUE**

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