



Vascular Society of New Jersey
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Monthly Report

September 2010

REGISTER NOW

VSNJ Annual Meeting

Highlawn Pavilion, West Orange, NJ

October 28, 2010

"EVAR: Current Update and the Next 5 Years"

with Frank Criado, MD, FACS, FSVM

Union Memorial-MedStar Health

Baltimore, MD

download invitation at www.vascularsocietynj.org

The SVS has asked for a copy of the VSNJ membership list so they can solicit non-members into their organization. Before we release this list, we want to offer our valued members the opportunity to "opt out" - and therefore, your names will not be released to the SVS. If you would prefer not to receive information from the SVS, please email the VSNJ office at LMYERS@BLYNCHASSOCIATES.COM by September 15. Thank you.

From the Statehouse

Beverly J. Lynch

The Legislature is gearing back up for what's expected to be a busy Fall season. Committee meetings and voting sessions begin in earnest on September 12. Focus continues on the "tool kit" and tax/revenue saving measures. The physician community (and 22 member coalition) will continue its efforts on the out-of-network reimbursement measures, and our proactive campaign.

Congressional races will dominate the election scene here in New Jersey this Fall. Two New Jersey State Senate seats are being contested - one in Mercer County and one in Camden County, but otherwise, state races will take place next year.

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Newly Enacted Collection Station Regulations

The New Jersey Department of Health and Senior Services ("DHSS") has adopted new regulations at N.J.A.C. 8:44-2.14 ("Regulations"), which significantly impact laboratories that operate collection stations in physician offices. The Regulations became effective July 19, 2010, and did not grandfather existing collection station arrangements with physicians. Therefore, immediate compliance is necessary.

Specifically, pursuant to the Regulations, a clinical laboratory that operates a collection station in a physician's office is now limited to collecting specimens only from patients of the physician's office in which the collection station is located, and must comply with the following provisions:

1. The collection station must be licensed by DHSS and the license must be prominently displayed in the collection station area;
2. No reimbursement, fees, rent, or any type of direct or indirect payment may be made to the physician by the clinical laboratory;
3. Employees of the clinical laboratory are not permitted to perform services for the physician that are normally the responsibility of the physician's staff, such as taking patient vital signs or other nursing functions, drawing specimens or performing testing for the physician's office laboratory, or performing clerical services;
4. The clinical laboratory and the physician's office may not share employees or independent contractors;
5. Except as necessary for the reporting of test results, the clinical laboratory may not provide supplies, waste disposal services, test kits for the physician's own use, electronic medical records systems or other goods or services to the physician; and

6. A copy of the signed lease or agreement must be made available to DHSS upon request.

As set forth above, although a clinical laboratory may not pay rent to a physician for space for a collection station, a copy of the lease agreement (if one exists) between a physician's office and a clinical laboratory must be provided to DHSS upon request. While the Regulations do not require a clinical laboratory to have a written lease agreement with a physician, DHSS stated in its notice of the adoption of the Regulations that DHSS shall "encourage laboratories operating collection stations in physician offices to have a written agreement that outlines the terms of the space arrangement and delineates the laboratory's responsibilities for compliance with the proposed rule."

On the other hand, the Regulations do not prohibit laboratories from operating a patient service center in a building owned by physicians or occupied by physicians' offices; provided that the patient service center is not located in a physician's office, and provided further that the patient service center is:

1. Open to and serves the general public, and is not restricted to serving one or more specific medical practices;
2. Located in a freestanding building or occupies space in a public access building;

3. Accessed directly through an exterior building entrance or from a public access foyer or hallway that clearly identifies the name of the laboratory and the days and hours of operation;
4. Not accessible through a physician's office;
5. Identified to the public by clearly visible signage on the exterior of the building, is listed in the building on-site directory, and advertisements list the address and telephone numbers of the patient service center;
6. Self-contained with regard to all aspects of operations, including the waiting room, reception area, phlebotomy rooms, restroom facilities and specimen and supply storage areas, except that the patient service center may share a common waiting area that is used by all tenants of a building or a floor of the building, provided that two or more tenants renting separate office spaces are not referring physicians or healthcare providers; and
7. A copy of the signed lease is made available to DHSS upon request.

Proposed 2011 Medicare Physician Fee Schedule

On July 13, 2010, the Centers for Medicare & Medicaid ("CMS") published its proposed 2011 Medicare Physician Fee Schedule ("Proposed Rule") which contains the following provisions:

- **Notice For Imaging Services.** The proposed rule would clarify the requirement in the Patient Protection and Affordable Care Act, as modified by the Healthcare and Education Reconciliation Act of 2010 (collectively, the "Act"), relating to the requirement that patients referred for imaging services under the in-office ancillary services exception to the Stark Law, be notified in writing that they may obtain such services from someone other than the referring physician and the requirement that the referring physician must provide a list of alternative providers in the area in which the patient resides. The Proposed Rule provides that the disclosure requirement would be effective January 1, 2011 (not retroactively to January 1, 2010). The Proposed Rule also clarifies that the notice would apply to MRI, CT and PET imaging. However, CMS is seeking comments relating to whether the notice should apply to other imaging services. The notice must contain at least 10 other providers that must be within a 25-mile radius of the physician's office and nothing in the notice may suggest that the patients must use one of the suppliers on the list. The referring physician would also be required to maintain a copy of the notice signed by the patient in the patient's medical record.
- **SGR Formula.** The Proposed Rule provides that the calculations of the conversion factor would be reduced in 2011 by an additional 6.1%. This reduction would be in addition to the 21.2% reduction that is scheduled to go into effect on December 1, 2010 when the law that extended the delay of application of the 21.2% reduction expires and the 2.2% increase now in place expires.
- **PQRI.** CMS is proposing to lower the Physician Quality Reporting Initiative ("PQRI") threshold for claims-based reporting of individual measures from 80% to 50% to enable more physicians to participate in the PQRI program and qualify for incentive payments.
- **E-Prescribing Incentive Payments.** In order to qualify for Medicare e-prescribing incentive payments equal to 1% of a physician's total Medicare Part B charges, the physician is required to report the e-prescribing measure for 50% of all applicable services. In 2011 it is proposed that a physician would only need to report 25 visits in total to qualify. CMS is proposing that physicians who do not participate in 2011 would be subject to financial penalties unless the physician qualifies for an exemption.
- **Misvalued Services.** CMS is requesting the Relative Value Unit Update Committee (the "RUC") to review services to identify misvalued codes, including: (1) codes for high/volume/cost items on the RUC's

multi-specialty points of comparison list of procedures (e.g., cataract surgery, colonoscopy and biopsy, and cystoscopy); (2) codes with low work RVUs commonly billed in multiple units for a single encounter (e.g., sense nerve conduction tests and fluoroscope examination); (3) codes with high volume and low work RVUs (e.g., chest x-rays and breathing capacity tests); (4) codes with site of service anomalies (services initially performed inpatient which have migrated to outpatient); and (5) codes with 23-hour stays.

· Multiple Procedure Payment Reductions. CMS is proposing to expand the multiple procedure payment reduction to CT, CTA, MRI, MRA and ultrasound procedures provided to a patient in the same session, regardless of the imaging modality, and not limited to contiguous body parts. These are just some of the more significant provisions of the Proposed Rule. The comment period to the Proposed Rule closed on August 24, 2010.

CMS Issues Final Requirements for the Medicare EHR Incentive Program

On July 16, 2010, the Centers for Medicare and Medicaid Services ("CMS") announced its final rule to implement the provisions of the American Recovery and Reinvestment Act of 2009 (the "Act") providing incentive payments to eligible professionals ("EPs") and eligible hospitals for the meaningful use of certified electronic health record ("EHR") technology. The final rule was published in the Federal Register on July 28, 2010.

An EP is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, legally authorized to practice under state law. A qualifying EP is one who successfully demonstrates meaningful use of EHR technology during the EHR reporting period. Hospital-based EPs who furnish substantially all (90% or more) of their services in an inpatient hospital setting or emergency room are not eligible for incentive payments.

A qualifying EP can receive EHR payments for up to five years with payments beginning as early as 2011. The maximum amount of total incentive payments that an EP can receive under the Medicare program is \$44,900. For the first year in which an EP applies for and receives an incentive payment, the EHR reporting period is 90 days for any continuous period within the year. For every year thereafter, the EHR reporting period is for the entire year. Incentive payments under the program end in 2016. Under the Medicaid program, EPs can receive as much as \$63,750 over six years. EPs may not participate in both programs. However, they may switch from one program to the other one time. The purpose of allowing this is to allow an EP whose patient volume no longer makes him or her eligible for the Medicaid program to nevertheless continue to receive incentive payments that would encourage the meaningful use of certified EHR technology.

A qualifying EP will receive an incentive payment for 75 percent of the Medicare allowable charges for covered professional services furnished by the EP up to a maximum allowable payment. If an EP enters the program in 2011 or 2012, the first year maximum payment will be \$18,000. If the EP enters the program in 2013, the first year maximum payment will be \$15,000. Thereafter, the maximum payment for year two will be \$12,000, for year three - \$8,000, for year four \$4,000, for year five - \$2,000. Because the program ends in 2016, EPs who enter the program in 2013 will be eligible for a maximum of \$39,000 and in 2014 for a maximum of \$24,000.

Meaningful use criteria will be phased in over three stages. In stage one, the focus will be on electronically capturing health information in a coded format, using the information to track key clinical conditions, communicating that information for care coordination purposes and initiating the reporting of clinical quality measures and public health information. In stage one, there will be 25 objectives for EPs divided between 15 objectives in the core set and 10 objectives in the menu set. EPs must meet all of the requirements in the core set and 5 of the objectives in the menu set. In 2011, EPs may demonstrate their meaningful use by attestation. In 2012 and thereafter, EPs will be required to electronically submit clinical quality measures through certified EHR technology. The core set of objectives for EPs includes using computerized provider order entry for

medication orders, generating and transmitting permissible prescriptions electronically, and recording vital signs and chart changes. The menu set of objectives for EPs includes implementing drug formulary checks, sending reminders to patients for preventive and follow-up care, and submitting electronic syndromic surveillance data to public health agencies.

Stage two and three criteria will be developed and modified over time. Currently, it is envisioned that in stage two, the meaningful use criteria would expand on the stage one criteria to encourage the use of health information technology for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders and test results. In stage three, the goals will be to focus on promoting improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health outcomes.

Asset Protection: Most common planning mistakes and oversights

Last month I reviewed asset protection strategies for your primary home. As I mentioned, the greatest common denominator among the different areas of asset protection is ownership: who owns what and how. Your choice of ownership is where most mistakes occur.

The most common types of ownership for vacation/Second homes are Joint Tenancy with Right of Survivorship (JTWROS) and Tenants in Common (TIC). In the event of a lawsuit neither of these types of ownership would afford you much, if any, protection from creditors.

A better strategy would be to have your vacation home owned in a limited liability structure, such as a Limited Liability Company (LLC) or a Family Limited Partnership (FLP); or something called a Qualified Personal Residence Trust (QPRT). Both of these types of ownership will not only protect your home from potential lawsuits but also provide you with a vehicle to transfer your home in a tax efficient manner thereby lowering potential estate taxes.

There are many pros and cons to LLC/FLP ownership but assuming that they are set up, funded, and administered correctly they definitely are a viable alternative to provide very strong protection from creditors. They also provide you with a vehicle to gift portions of the value of your home, over time, to your children on a discounted basis.

Next month we will discuss how a QPRT works. Until then, if you have any questions, please feel free to call me at (877)972-7900 or e-mail me at dvargo@varbeco.com.

David J. Vargo, CFP®, CMFC

President, Varbeco Wealth Management, LLC

The New Jersey Lawsuit Reform Alliance

As New Jersey reached the dog days of summer in July, the New Jersey Supreme Court delivered a stifling blow to the Affidavit of Merit Statute. In a 6 - 1 decision, the Court ruled that plaintiffs don't need to explain why they can't find appropriately qualified experts to testify in malpractice cases. They need only to say that they gave it a shot before seeking a good-faith waiver under the Affidavit of Merit Statute.

In the case before the Court, *Ryan v. Renny*, the plaintiff's attorney filed suit against a board-certified gastroenterologist, saying that the doctor deviated from accepted standards of care when he perforated a

bowel during a colonoscopy. The attorney tried and failed multiple times to secure affidavits of merit from at least three different board certified doctors in the same field, but all refused. The justices ruled that even though the attorney failed to secure an affidavit of merit from a board certified doctor in the same field, they would accept that he tried to do so, and allowed an affidavit of merit from a surgeon who wasn't board certified and had not performed the procedure in many years. Justice Roberto Rivera-Soto was the lone dissenter, who said that the defendant has a legislative right "to be free of malpractice claims of questionable merit."

NJLRA Executive Director Marcus Rayner has been raising awareness about the consequences of this decision, issuing a press release and speaking to members of the media. Read Linda Moss's August 9th story "Medical Malpractice Reform Advocates Urge Action Now" in NJ Spotlight, <http://www.njspotlight.com/stories/10/0808/1022/>, or visit our website, www.njlra.org, to learn more.

Mark Your Calendar

October 28, 2010 - VSNJ Annual Meeting - Highlawn Pavilion, West Orange, NJ

December 4, 2010 - ACS-NJ 59th Annual Scientific Meeting

March 9, 2011- VSNJ 33rd Annual Meeting- Nanina's In The Park, Belleville, NJ

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