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## Monthly Report

### October 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](http://www.vascularsocietynj.org)*

#### From the Statehouse

**Beverly J. Lynch**

Focus continues on the national election picture....and the hotly contested results for the US House of Representatives, US Senate and several gubernatorial races. Here in New Jersey, we have two key house races being watched by the pundits in Washington - districts 2 and 12. Next year, the entire New Jersey State Legislature is on the ballot - and 2011 will be a very interesting year featuring races testing the Christie mid-term support.

In Trenton, work continues in committees and floor votes. Over 6,000 bills have been introduced thus far, and we are tracking over 230 of them for the physician community. Key among them are efforts to lower the reimbursement for out of network physicians, efforts by nurses to independently deliver anesthesia in hospital settings (without physician supervision), and continued discussion over the medical liability crisis. There is also a coalition working to overhaul the pre-hospital / emergency medical services system.

As always, contact me with questions, comments, feedback and suggestions.

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**New Jersey Out-of-Network Update**

We have been spending an enormous amount of time fighting various attempts in the Legislature to regulate out-of-network ("OON") providers. This is one of the most important issues that providers have faced -- both OON and in-network providers alike. If the OON market evaporates, so will any leverage to negotiate in-network contracts. We will be fighting every step of the way.

You will recall that in the beginning of the summer Senator Nia Gill (D-Montclair), Chair of the Senate Commerce Committee, attempted to move out of her committee S-1742 which, if enacted would criminalize the waiver of co-payments and deductibles. The bill didn't make it out of committee that day, a small victory in a protracted war. We continue to monitor this bill in the Senate.

In the Assembly, Gary Schaer (D-Passaic), Chair of the Assembly Financial Institutions and Insurance Committee, has been on the record for some time that he intended to introduce OON legislation this fall. In this regard, Assemblymen Schaer held 6 meetings on OON issues over the summer with various stakeholders -- 3 meetings with healthcare providers, and 3 meetings with insurance companies. He then selected 4 representatives from each side to form a "working group" to determine whether consensus could be reached on issues related to New Jersey's OON market. I was one of the four members on the provider side.

The OON working group met 5 times over August and September. As you can imagine, we had some fairly vibrant discussions. The working group was informal and served strictly in an advisory capacity. Obviously, the contents of any proposed legislation will be solely up to Assemblyman Schaer and his colleagues in the Assembly.

We expect Assemblyman Schaer to introduce the bill shortly. I will obviously reach out for you then. Rest assured we are locked and loaded for this one.

**Proposed Federal Rules to Prevent Fraud**

On September 23, 2010, the U.S. Department of Health and Human Services ("HHS") published

**in the Federal Register, proposed rules to implement provisions of the Affordable Care Act. If adopted, the proposed rules would strengthen and expand the Centers for Medicare and Medicaid Services' ("CMS") fraud prevention efforts by targeting criminals who pose as providers to collect Medicare, Medicaid and Children's Health Insurance Programs ("CHIP") funding. According to CMS, the rules would give federal officials increased authority to detect fraud early and help them reduce billions of dollars in improper payments made through Medicare and Medicaid.**

**The rules would provide increased scrutiny to \$900 billion in annual spending in Medicare, Medicaid and CHIP by allowing CMS to suspend payments to providers if there is credible evidence or allegation of fraud and require state Medicaid programs to terminate an individual or entity's participation in the program if the individual or entity has been terminated under Medicare or another state's Medicaid program. In addition, CMS would be allowed to rate various types of medical providers and suppliers by their risk for engaging in fraud, as "limited," "moderate," or "high." The following screening tools would apply to those in the limited risk category (e.g., individual practitioners): verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; verification that a provider or supplier meets applicable licensure requirements; and database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type. For those providers and suppliers in the moderate risk category (e.g., hospices), CMS proposes that Medicare contractors will conduct unannounced pre- and/or post-enrollment site visits in addition to those screening tools applicable to the limited level of risk. Those at highest risk (e.g., new home health agencies) would undergo fingerprinting and criminal background checks in addition to other screening measures applicable to all categories. CMS is proposing that these screening tools would be applied to owners, authorized or delegated officials or managing employees of any provider or supplier within the high level of risk.**

**Comments are due by 5pm on November 16, 2010 and can be submitted electronically at <http://www.regulations.gov> or by regular mail to Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attention: CMS-6028-P, P.O. Box 8020, Baltimore, MD 21244-8020.**

#### **Health Care Administration Board Approves Proposal for Readoption with Amendments of Licensing Standards Governing Hospital Services**

**The New Jersey Health Care Administration Board met recently and approved for publication revised hospital licensing standards, N.J.A.C. 8:43G-1.1, et seq., proposed by the New Jersey Department of Health and Senior Services ("DHSS"). The official rule proposal appeared in the New Jersey Register on August 16, 2010. The proposal includes the amendments discussed below.**

**DHSS proposes changes to subchapter 6 to include a definition of advanced practice nurses specializing in anesthesia and to substitute this term throughout the subsection for the now outdated terms of certified registered nurse anesthetist and registered nurse anesthetist. An advanced practice nurse specializing in anesthesia would be authorized to administer anesthesia in a hospital provided that it is done in accordance with a joint protocol with a collaborating anesthesiologist. The rules would require that the joint protocol include a section governing the**

availability of the collaborating anesthesiologist for consultation on site, on-call or by electronic means and the presence of an anesthesiologist during induction, emergence and critical change in status.

DHSS also proposes to amend subchapter 7A of the regulations, which establishes the standards for comprehensive and primary stroke centers, to include a definition of the term "hospitalist." Under the proposed rules, "hospitalist" will be defined as a "licensed physician whose primary professional focus is hospital medicine and who is board certified or board eligible in critical care, neurology, emergency medicine, family medicine, general internal medicine, surgery or anesthesiology." Further, DHSS proposes to amend this subchapter to add hospitalists to the list of professionals who are authorized to serve on an acute care stroke team. The proposed amendment will also add critical care, family medicine, general internal medicine, general surgery, and anesthesiology to the list of specializations in which a team member must hold board certification or board eligibility to be eligible to serve on the team.

Finally, DHSS proposes to amend subsection 16 to provide that a medical history and physical examination may be performed within 30 days prior to an admission (rather than the former seven day requirement) or within 48 hours of admission (rather than the former 24 hours requirement) and to require that a written assessment of the patient be performed by an attending physician, advanced practice nurse or physician assistant no earlier than seven days prior to admission and no later than 48 hours of admission for the purpose of assessing the patient's medical status since the preadmission medical history and physical examination. This proposal specifically authorizes advanced practice nurses and physician assistants to perform assessments in a hospital setting. Currently, physicians are the only professionals authorized to conduct these assessments. The amendment makes the rule consistent with the Advance Practice Nurse Certification Act and the Physician Assistant Licensing Act which authorizes advanced practice nurses and physician assistants to perform these assessments.

The comment period for the proposed regulations will close on October 15, 2010.

#### **Proposed Rules Relating to Physician Assistant Scope of Practice**

The New Jersey State Board of Medical Examiners ("BME"), in consultation with the Physician Assistant Advisory Committee, is proposing to amend regulations concerning the scope of practice for licensed physician assistants. Currently, physician assistants working under the direct supervision of a licensed physician may facilitate the referral of patients to health care facilities and other agencies and resources in the community. The proposed amendment would allow physician assistants to make the actual referral of patients to such services on behalf of the supervising physician, rather than just facilitating such referral, and would also allow physician assistants to make referrals to health care practitioners in addition to facilities and other agencies and resources.

In addition, the BME is proposing to amend the regulations governing supervision requirements for physician assistants in all settings to no more than four physician assistants to one physician at any one time.

**The comment period for the proposed regulations will close on November 6, 2010.**

### **Rule Proposals from the New Jersey State Board of Medical Examiners**

**The New Jersey State Board of Medical Examiners ("BME") has proposed to readopt its regulations governing licensed professionals, N.J.A.C. 13:35-1.1, et seq., with certain amendments aimed at clarifying and updating the language of the rules. Most of the proposed amendments consist of minor language changes, but there are also substantive amendments proposed, several of which are highlighted below:**

- **The BME could require a participant in a graduate medical education program to submit to medical testing and monitoring, or psychological evaluation, or skills assessment if the participant's continued practice could pose a risk to public health safety or welfare;**
- **Physicians who prescribe contact lenses would be required to issue a prescription directly to the patient upon the completion of a contact lens fitting;**
- **Physicians would be required to utilize the New Jersey Electronic Death Registration System when pronouncing death;**
- **Licensees would be required to maintain, as part of a patient's medical record, copies of any printouts of records made while bringing their computerized medical record system into compliance with BME rules; and**
- **Records from other physicians or healthcare providers that are held by a licensee as part of a patient's medical record would be subject to the same rules concerning access as the records prepared by the licensee.**

**The BME also proposes to amend the current rule enumerating limitations applicable when a licensee prescribes, administers or dispenses controlled substances. The proposed standards would allow a practitioner to prescribe multiple prescriptions that can equal up to a 90-day supply of Schedule II drugs, provided that:**

- **Each prescription is issued for a legitimate medical purpose;**
- **The practitioner provides written instructions as to the earliest date on which a pharmacy may fill each prescription;**
- **The practitioner determines that multiple prescriptions do not create an undue risk of diversion or abuse; and**
- **The practitioner complies with all other state and federal laws and regulations.**

### **OIG Approves Proposed Arrangement Offering Free Pre-Authorization Services**

**The United States Department of Health and Human Services Office of Inspector General**

("OIG") recently posted an advisory opinion approving a hospital's proposal to provide free insurance pre-authorization services to patients and physicians, concluding that the proposed arrangement presented a low risk of violating the federal anti-kickback statute.

The requesting hospital proposed to offer free pre-authorization services (the process where certain medical or other information is provided to insurers in order to obtain an authorization code that permits coverage of a health care service) for all patients referred to its imaging services, through its Pre-Access Department (the "Department"). The service would be made available to all patients and referring physicians using the hospital, without regard to any physician's overall volume or value of referrals.

After review of the proposed arrangement, the OIG concluded that the free pre-authorization services present a low level of risk of influencing referrals, and it would not impose administrative sanctions on the hospital under the anti-kickback statute for the following reasons:

- The pre-authorization services would be equally available to all patients and physicians, and no particular referring physicians would be targeted; although the service may relieve some physicians of their pre-authorization obligations, thus potentially benefiting some and not others, such relief would occur by chance, not design.
- The proposal contains safeguards that lower the risk of fraud and abuse; no payments will be made to physicians, and there are no ancillary arrangements with referring physicians that would otherwise reward referrals to the hospital.
- The Department would operate transparently by requiring Department personnel to inform insurers that they are hospital employees and disclose the nature of the program. Also, each physician would receive copies of all information submitted to the insurer for pre-authorization. Importantly, Department staff would have little occasion to influence referrals because patients would have already selected the hospital prior to receiving the pre-authorization service.
- The hospital has a legitimate business interest in providing this service because its payments are at stake if pre-authorization information is submitted incorrectly. The OIG concluded that the hospital's financial interest in ensuring the accuracy of pre-authorization provides a rationale that is clearly distinct from a scheme to gain favor with referral sources.

## **Asset Protection: Most common planning mistakes and oversights**

As I mentioned in last month's article, 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. Last month we discussed the potential benefits of using a Limited Liability Company (LLC) or a Family Limited Partnership (FLP).

Another strategy would be to have your home owned by a Qualified Personal Residence Trust (QPRT). If set up and funded properly, a QPRT will not only provide you with excellent protection from potential creditors but can also reduce the size of your taxable estate thereby reducing estate taxes.

Here's how it works. You gift the residence to an irrevocable trust for the benefit of your children and retain the right to live in the home for a fixed number of years. At the end of the term, assuming that you are still living, your children will now own your home. The value of your home is discounted because it is based on its remainder interest. The amount of the discount will be based on your age at the time of the gift and length of the trust term. Once gifted, all future capital appreciation is removed from your estate.

Here is an example of a recent QPRT that we did for a client's vacation home in Long Beach Island. Prior to the recent real estate market decline the home was valued at \$1,750,000. A recent appraisal valued the home at \$1,450,000. The remainder interest discount brought the value of the gift down to \$950,000. Assuming that you outlive the term of the trust, the \$800,000 of assets are transferred to your kids free of gift and estate taxes. Furthermore, the value of all appreciation on the residence during the term of the trust is also removed from your estate.

When the term of the trust ends, if you want to remain in the residence, you will have to pay fair market rent to your kids. This might not sound appealing but actually provides further estate planning advantages because rental payments are removed from your estate and are not subject to gift taxes.

This is a very complicated strategy that I have just touched the surface on. If you would like to discuss in further detail please contact me at (877)972-7900 or [dvargo@varbeco.com](mailto:dvargo@varbeco.com).

I wish you and your families a very healthy and happy holiday season.

David J. Vargo, CFP®, CMFC

President, Varbeco Wealth Management, LLC

## The New Jersey Lawsuit Reform Alliance

The [New Jersey Law Journal](#) released a list of the top 20 highest personal injury awards in New Jersey this year. One of these cases, which ranked as the second-highest award, is particularly troublesome. In *Kim v. Newark Beth Israel Medical Center*, it was alleged that an obstetrician was negligent for delaying a Caesarean section on a patient who later delivered a child with cerebral palsy - twelve years ago. The facts behind the [\\$18.5 million jury verdict](#) are disturbing. The doctor in question was a part-time contract physician at Newark Beth Israel Medical Center. Nevertheless, the doctor was found to be an employee of the hospital, whereby making Newark Beth Israel liable. The patient was also a practicing Jehovah's Witness, and had stipulated before childbirth that she could not receive a blood transfusion if it became necessary.

By all accounts, the plaintiff benefitted heavily by the Court's finding that the doctor was an employee of the hospital - which raised the potential award from the doctor's \$1 million in insurance to the hospital's insurance ceiling of \$150 million. The hospital is now responsible for the multi-million dollar verdict.

***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