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Private payers cracks down on suspect arrangements

State courts vary widely in their response, attorneys say

While most health care compliance efforts focus on government efforts to enforce federal laws, health care attorney **Laura Keidan Martin** says compliance officers should be aware of new initiatives insurance companies are undertaking to combat arrangements that fall outside state laws or prompt overutilization. While these efforts have not received the same press as some federal initiatives, they already have met with some success in various state courts across the country, Martin says.

"Private payer enforcement has always been more important than most providers thought, and its importance is increasing," says **Bill Sarraille**, a health attorney with Arent Fox in Washington, DC.

According to Martin, an attorney with Katten Muchin in Chicago, states have adopted a range of statutes to prohibit arrangements that result in overutilization or that put profit motive ahead of patient interest. Laws on the books that address these problems include fee-splitting bans, kickback bans, and state self-referral statutes. **(See related story, page 4.)**

Possibly due to a lack of enforcement resources and poor reporting mechanisms, most of these state statutes have gone largely unenforced, reports Martin. "As a result, unlawful arrangements that incentivize the provision of

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How to deal with minors under HIPAA

One of the challenges facing providers under the Health Insurance Portability and Accountability Act (HIPAA) will be how to deal with minors, including newborns.

Health care attorney **Susan Bonfield** of Fox Rothschild in Philadelphia, notes that the final privacy regulations eliminated the requirement that there be a specific consent to use or disclose protected health information. Now providers can obtain a written acknowledgement in whatever fashion they like and, in an emergency, document good-faith efforts if they are unable to obtain a written acknowledgement. "They still need to

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Sheehan outlines emerging fraud theories

An area that is likely to see increased use of the False Claims Act is "the theory of worthless services," says **James Sheehan**, the longtime assistant U.S. Attorney in the Eastern District of Philadelphia, who last month was promoted to the post of associate U.S. attorney for civil programs.

According to Sheehan, the use of the False Claims Act is changing along with reimbursement systems. He notes that cost reports are being replaced by payment for specific diagnoses and treatments as well as capitation. In neither instance is there a claim that explicitly says what services were provided. "Rather, it says, 'We have a patient with medical necessity for certain treatments, and we promise to provide medically necessary care to do what is appropriate.'"

Sheehan contends that the government should not be involved in false certification cases where the violation does not go to the essence of the

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Private payers

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medically unnecessary health care goods and services run rampant in many states," she asserts. "In many states, you see entire industries springing up where the arrangements don't comply with state law."

Because overutilization is difficult and time-consuming to prove on a case-by-case basis, insurers now are taking a more systemic approach to the problem, Martin says.

To date, most of the arrangements that have been targeted by insurance companies have involved blatant violations of state law, she says. These arrangements include several variations. The first is in states with corporate practice of medicine statutes in which medical providers are controlled by laypersons. Martin says these arrangements come in many forms, including business corporations that directly employ physicians.

The second scenario involves laypersons or lay entities that contract with physicians to serve as the "paper owners" of medical practices.

Finally, there are arrangements in which a layperson or lay entity exerts control over the medical practice through a management agreement structure and derives all the profits from the practice through the management fee.

One specific scenario Martin points to is abusive diagnostic testing arrangements that allow the billing entity to capture the markup on services performed by others.

She says this type of arrangement surfaced frequently in Florida concerning Magnetic Resonance Imaging (MRI) services because there was an oversupply of MRI facilities and too few patients. Although MRI companies performed all the work, some brokers billed insurers at a 200% to 400% markup and pocketed the difference, she says.

Martin says these arrangements can run afoul of anti-kickback statutes (because the spread between the third party's fees and the billed fee constitutes an inducement for referrals) as well as fee-splitting prohibitions, because the referral source and actual provider split fees.

They also can violate self-referral prohibitions if a physician acts as the "broker" and if state law bars out-of-office referrals absent on-site supervision.

"The Florida MRI cases have been creating quite a stir among insurers in other states that are watching their imaging and diagnostic costs climb," Sarraille notes.

As people caught on to that arrangement, Martin says diagnostic facility "leasing" arrangements, which are one step removed from a purchased service arrangements, started to emerge. These agreements call for the referral source to "lease" space, equipment, personnel, and any necessary supplies from a third party for a fixed fee per test or per period.

The referral source, which provides no component of the service, then bills the insurer at a significant markup.

"The radiology market is torn over these lease relationships, with opinion about them sharply divided," Sarraille observes.

Finally, Martin points to portable diagnostic equipment and staffing arrangements. Under these arrangements, providers capture additional revenue streams by hiring diagnostic testing companies to bring equipment and technicians to their offices to perform diagnostic tests on their patients, typically on a below-market, "per-click" fee basis.

The referring physician then bills for the test at a significant markup. The diagnostic testing company typically bills for the interpretation, which

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Martin says are often performed by an out-of-state physician who is willing to provide below-cost testing as a quid pro quo for the professional service referral.

"Like the first two scenarios, you have a situation where the practice is not providing any real supervision," says Martin. "It is simply sending referrals to the testing company."

One legal theory insurance companies have been asserting is that by fraudulently incorporating a medical practice or entering into a sham arrangement, that is fraud on the insurance company.

"Dropping a dime on the providers and trying to initiate investigations by insurance departments, state attorneys general, and medical boards are clearly tactics that insurers are increasingly inclined to employ," says Sarraille, who has handled some of these cases.

Martin says courts have taken different positions regarding these claims. However, she says a number of courts that have ruled that if an arrangement violates state law, there is no right to payment for those services. "The battle is still raging, and the issues are far from resolved," she says. ■

Fraud theories

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deal. "What you want to do is focus on cases where a jury can find there is a nondelivery of the service that is understood and promised; and second, that it is done intentionally or with reckless disregard," he says.

Sheehan points to three areas where he says "the theory of worthless services" is likely to apply. The first involves nursing homes and residential care situations, specifically cases that involve decubitis ulcers, inadequate nutrition, patient restraints, patient control through medication, as well as falls, fractures, and "wander-offs."

The second area is behavioral health. Sheehan highlights a recent case the state attorney general in Minnesota brought against Blue Cross where the contract stated that access to mental health care would be provided but the care was unavailable.

"The point is that you get paid for behavioral health services as part of your capitation payment," he says. "And part of what you pay for is the ability to access the care when you need it."

Finally, Sheehan points to clinical trials where patients participate in studies funded by the federal government. Among the key questions: Are they telling the patient the truth? Is there compliance with the independent review board requirements? Should the study have gotten off the ground?

When it comes to research fraud, Sheehan says the question is not only specific certifications but whether the purpose of the research itself is compromised by scientific misconduct.

Kathleen McGuan, a partner with Reed Smith in Washington, DC, says that what the government overlooks in its zeal to apply the False Claims Act to quality-of-care issues is the amount of money being paid for these services.

"The fact of the matter is, you cannot have one nurse, or even one nursing assistant, for every patient or every resident in a nursing home on what Medicaid pays to the nursing home," she maintains. "The answer might be to pay more money, but the answer is not to walk behind the regulator and say it is fraud."

McGuan argues that of all the applications of the False Claims Act pioneered by Sheehan, the least promising for the government is one modeled after a case in which it was argued that claims for nursing home services did not meet the quality of care required by federal regulations and conditions of participation.

McGuan points out that every nursing home that participates in the federal Medicare and Medicaid program has been certified by the Centers for Medicare & Medicare Services.

She argues that the certification is a conclusion of law that the nursing home is providing good enough care to participate in the program. "It is not compliance; it is substantial compliance," she argues. "It is absolutely clear that the nursing home can be surveyed, deficiencies can be found, and they can continue to bill Medicare and Medicaid, and it is not a false claim."

Robert Griffith, a health care fraud and abuse attorney in Boston, takes a similar view. "Too often, what the government is paying for is not spelled out in sufficient detail to credibly claim that the failure to provide one or more elements of care translates into criminal conduct," he says. ■

HIPAA privacy

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provide a notice," she says. "It made it easier in that it eliminated one mandated document, but the spirit of the requirement is still there."

According to Bonfield, one problem area for providers is newborns, who are people entitled to their own notice. The mother always will be the personal representative, she points out. "You might have a case where a mother is deemed not competent," she explains. "Likewise, the mother might be a minor." In those cases, Bonfield says providers must look to the state law. For example, it may be reasonable to have some sort of waiting period as long as the notice explains what is going to happen.

When it comes to minors covered by their parents' health plans, Bonfield says a different set of questions must be addressed. If a minor turns 18 and is covered by the parents' health plan, one of the issues that will arise is whether the minor must be informed about the existence of a notice. "The HIPAA regulations say you don't, but there is a sense among some health plans that you should," she says.

Another issue that providers will confront dealing with minors involves states where the majority age is at variance. For example, the majority age in New Jersey is 18, while it is 21 in Pennsylvania. "This raises the question of what to do when a New Jersey provider receives a Pennsylvania resident for services who is 20 years old," says Bonfield. "There is going to have to be some close scrutiny regarding the different state laws."

Bonfield says these are just some of the areas providers should consider when they are drafting procedures on minors and notices. "Once you understand HIPAA, and you start drafting procedures, you suddenly realize that you are going to have to think through some of these real-life situations," she explains.

Bonfield says that if health plans opt to provide only one notice to the person who is listed as the policy holder and it is his or her responsibility to pass it on to everybody else, that is their right under the law. However, she says, plans must provide notice every three years that the notice is available. "The question is whether that should go to all enrollees as opposed to just the enrolled individual," she says. ■

State health fraud laws proliferate

According to **Laura Keidan Martin**, a health care attorney with Katten Muchin in Chicago, there are a number of state laws that form the basis for the current private payer initiatives into health care fraud. "These laws vary quite a bit from state to state," she adds. They include:

- **Anti-kickback laws/patient brokering prohibitions.** Several state anti-kickback laws are broadly worded to bar any remuneration for referrals. "Unlike the federal anti-kickback statute, these statutes apply regardless of payment source," Martin says. Other state kickback laws apply regardless of payer but only to certain types of payment practices, while other states bar kickbacks only under state Medicaid programs. Some of these laws are criminal, while others are found in medical practice acts and make acceptance of kickbacks grounds for physician discipline.
- **Fee-splitting prohibitions.** In many states, the fee-split prohibition is part and parcel of the kickback prohibition and bars a provider from dividing professional fees in return for referrals. Martin says many state licensing statutes bar physicians and often other providers from splitting professional fees in return for referrals except within a lawfully organized group practice.
- **Self-referral prohibitions.** Several states have adopted self-referral prohibitions for designated health services if the practitioner has an investment interest of financial relationship with the entity, she says. Other state statues apply to all health care services and would bar providers from making referrals to any entity for any health care services outside their group practice unless they personally are involved in the patient's care.
- **Corporate practice of medicine prohibitions.** In many states, it is unlawful for a layperson to employ a physician or to own a physician practice. Some states expressly bar the practice of telemedicine across state lines without a state medical license or special permit, unless a specified exception applies. Virtually all other states have interpreted their general prohibitions on the unlicensed practice of medicine to bar the practice of medicine across state lines unless a "consultant" or other limited exception applies, she says. ■