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HEALTH LAW BULLETIN

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Court Holds that Hospital Failed to Satisfy Stark Law Personal Services Exception

BY DAVID A. MANKO

On January 21, 2009, the U.S. Court of Appeals for the Third Circuit released its opinion in an important case regarding the meaning of the Stark Law, U.S. ex rel. Kosenske vs. Carlisle HMA, Inc., No. 07-4616. This case is important because it explains the Stark implications where a hospital grants exclusive privileges to an anesthesia group (including the use of hospital owned equipment, supplies and facilities) and the anesthesia group refers pain management patients to a facility owned by the hospital.

Specifically, the hospital entered into an exclusive contract with the anesthesia group in 1992, at which time the anesthesia contract was drafted. Several years later the hospital opened up a pain clinic, in which pain management physicians who were associated with the anesthesia group conducted a chronic pain practice without paying rent or compensation for using the hospital's equipment and personnel. The anesthesia services agreement was not amended to show how this new pain management arrangement constituted fair market value.

The Court concluded that without a written contract provision setting forth how the free rent, personnel, and equipment constituted fair market value, the arrangement failed to meet the Stark personal services exception. The Court explained that there was no reference in the 1992 agreement to consideration that the anesthesia group was receiving for its services from the hospital sufficient to satisfy the fair market value requirements of the Personal Services exception under the Stark law. The Court further stated that the addition of the hospital's new pain management capabilities was additional compensation to the anesthesiologists without consideration of fair market value.

A narrow reading of the case essentially states that an anesthesia group that provides pain management services at a hospital outpatient clinic or ambulatory surgery center, in which the group has an office but does not pay rent for the space, equipment, or personnel, must have a written contract with the hospital that sets forth how the free rent, space, personnel constitutes fair market value. Prior to this case, it was unsettled as to whether the hospital and physician group needed a written contract that demonstrated the calculations which confirm the fair market value of that arrangement.

However, the holding of this case may have broader implications. Specifically, it is likely that the government will use this case to reach other types of physicians who have exclusive privileges and also treat patients at hospital owned ambulatory surgery centers and other outpatient facilities. ■

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Major Developments Affecting New York Fraud and Abuse Investigation

BY BETH GREEN

Two recent developments will have an immediate impact on New York providers of medical services:

First, on February 2, 2009, New York State Inspector General James Sheehan reported that the Office of Medicaid Inspector General (OMIG) is developing a disclosure protocol for providers to self-report fraud and abuse issues discovered through the provider's own compliance program. The OMIG expects to release the protocol by the end of February. Mr. Sheehan stated that the protocol would provide certain "benefits" to providers who self-report.

Second, the Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractor (RAC) program was scheduled to begin in November 2008 in New York, with outreach meetings to be held with CMS and Medicare providers before the program launch. These meetings were delayed until February 2009 because of protests filed with the Government Accountability Office by two companies that unsuccessfully bid to become permanent RACs. These protests were settled on February 4th. The stop work order has been lifted and CMS will now continue with the implementation of the RAC program in New York.

We have increasingly seen clients become the subject of audits, through the New York OMIG program and through the RAC program. Providers should be prepared for enhanced auditing activity.

THE OMIG PROGRAM

The Federal-State Health Reform Partnership (F-SHRP), approved by Congress in September 2006, created the OMIG in order to expand New York's fraud and abuse recovery unit. F-SHRP allocated $1.5 billion to New York State with the contingency that New York State must return $1.6 billion to the Federal government over five years from fraud and abuse recoveries by New York State. Should the OMIG fail to meet stated recovery targets, the penalty will be monies owed to the federal government equaling the difference between the actual and target recoveries.

In 2008, the OMIG recovered $551 million, the largest annual recovery of any state Medicaid program. Mr. Sheehan expects the OMIG to return $695 million to the Medicaid program this year and $820 million in fiscal year 2009-10. The benefit to New York of the recently announced self-disclosure program is an increase in funds returned to Medicaid with decreased investigative costs to be expended by New York.

In an attempt to find fraud, waste and abuse in New York's $48 billion Medicaid program, the OMIG intends to increase by 50% the number of providers currently under review. Any provider who received a Medicaid payment may be investigated. In addition, the Bureau of Investigations and Enforcement will investigate fraud in business arrangements that allegedly violate the federal health care anti-kickback statute and the statutory limitation on self-referral. Auditors may review services provided for six years from the billing date for such services.

Over the last several years, the OMIG engaged auditing companies

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This publication is purely informational and not intended to serve as legal advice. Your feedback is welcomed.

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Top 10:
Compliance Tips

BY WENDY STIMPFL

1. Make compliance a priority!

2. Make certain all employees are properly trained and understand compliance requirements.

3. If you are audited, respond with the assistance of counsel.

4. Don't be afraid to appeal audit findings.

5. NEVER alter medical records to justify coding.

6. Properly and promptly return all identified overpayments.

7. Conduct internal audits of your billing practices annually.

8. Treat each billing inquiry or communication seriously, regardless of the source.

9. Don't joke with employees about billing matters - every employee is a potential whistleblower.

10. Understand the complexities of the anti-referral and anti-kickback statutes before structuring any business deal.

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Physician Joint Venture Arrangements Under Heightened Scrutiny

BY GEORGE CHORIATIS

The Department of Health and Human Services Office of Inspector General (the "OIG") has repeatedly expressed a specific longstanding concern under the federal healthcare program anti-kickback law about joint venture arrangements between a physician who is in a position to refer patients (the "referring physician") and an entity that provides items and services that are reimbursable under a federal health care program, including Medicare (the "supplier"). The OIG is concerned with such joint venture arrangements to the extent that one of their purposes is to lock up a stream of referrals from the referring physicians to the suppliers and to compensate the referring physicians indirectly for these referrals.

The focus of the OIG's concern is on those joint ventures in which the referring physician is not actively involved either as an investor or as an operator. In these situations, the OIG views the financial benefits of the venture to the referring physician not as a return on investment or labor but as a kickback for patient referrals. The OIG has identified certain characteristics that, taken separately or together, potentially indicate a joint venture arrangement that would be suspect under the anti-kickback law. Those characteristics include the following:

(a) New Line of Business. The joint venture enables the referring physician to expand into a health care service that can be provided to its existing patients.

(b) Captive Referral Base. The joint venture predominantly or exclusively serves the referring physician's existing patient base and makes no or few bona fide efforts to serve new patients.

(c) Little or No Bona Fide Business Risk. The referring physician's primary contribution to the joint venture is referrals. The referring physician makes little or no financial or other investment in the business, delegating the entire operation to the supplier, while retaining profits generated from his or her referral base. Residual business risks, such as nonpayment for services, are relatively ascertainable based on historical activity.

(d) Status of the Supplier. The supplier is a would-be competitor of the new line of services provided by the joint venture and would normally compete for the physician's referrals. The supplier has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

(e) Scope of Services Provided by the Supplier. The supplier provides all, or many, of the following key services: day-to-day management; billing services; equipment; personnel and related services; office space; training; healthcare items; supplies and services. ■

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Recent Developments Affecting New York Fraud and Abuse Investigation

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as contractors to review records submitted and issue recovery demands in an effort to recover funds from hospitals, ambulatory care facilities, nursing homes, group practices and solo practitioners. Mr. Sheehan announced last week that the OMIG will be hiring more state employees to conduct investigations (and using outside contractors less).

RAC PROGRAM

Congress directed the Department of Health and Human Services (HHS) to conduct a three-year program using Recovery Audit Contractors to detect and correct improper payments in the Medicare program. During the three-year demonstration program in New York, California and Florida initially and later expanded to Arizona, Massachusetts and South Carolina (between 2005 and 2008), RACs identified and collected $992.7 million in overpayments. Given the success of the RAC program, Congress made the RAC program permanent and required the Secretary of HHS to expand the program to all 50 states and potentially to all providers who receive Medicare reimbursement by no later than 2010.

Soon after the completion of the upcoming outreach meetings, Medicare providers in New York may expect to begin receiving requests for medical records or overpayment demand letters. Specifically, RACs are tasked with detecting improper Medicare payments and correcting them by collecting overpayments from providers (and paying underpayments to providers).

RACs are permitted to attempt to identify improper payments resulting from incorrect payments; non-covered services (including services not reasonable and necessary); incorrectly coded services; and duplicate services. Changes from the demonstration program to the permanent program include: RAC reviewers have a maximum 3-year look-back period (with an initial review of claims paid on or after October 1, 2007); when performing coverage or coding reviews of medical records, registered nurses or therapists are required to make determinations regarding medical necessity and certified coders are required to make coding determinations; and RACs will not be able to retain their fees if the provider wins an appeal (which presumably will make the RACs more cautious).

PROTECTING YOUR PRACTICE

In most cases, if the OMIG or a RAC targets your practice with an audit, it will issue a recovery demand and/or make a request for documents. The steps that you can take to minimize your exposure from an audit of your practice include:

Compliance. It is imperative that you make compliance a priority. Every provider should ensure that his or her practice has a compliance program that contains the practice's compliance procedures and methods by which billing irregularities are addressed. Additionally, each practice should elect a compliance officer who is willing and capable of overseeing the practice's compliance program so that all procedures are up to date. A compliance program is most effective when reviewed and understood by each employee. Moreover, it is important to have regular compliance meetings and to evidence such meetings with the recording of minutes and attendance, if possible.

Respond with Assistance of Counsel. If you are audited, before responding, you should seek the assistance of legal counsel to initially help determine, and place limits on, the scope of the audit. In addition, an attorney can advise you on strategies for negotiating preliminary conclusions of the audit and assist in objecting to a final report and filing an appeal. If any matter escalates past the audit process, an attorney should accompany you to a hearing and should be consulted if auditors report you to the Office of the Attorney General and/or other enforcement agencies for potential criminal investigation and prosecution. ■

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