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HEALTH LAW BULLETIN

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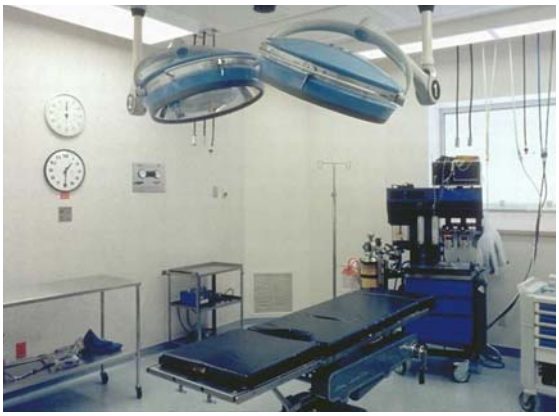
Doors may be closing on opportunities relating to Ambulatory Surgery and Diagnostic & Treatment Centers

By DAVID A. MANKO

As reimbursement rates continue to decline and operating overhead continues to increase, providers and business people in the healthcare industry continue to look for alternative revenue sources. These may include medical device and pharmaceutical consulting arrangements, equipment acquisitions, the addition of new modalities and disciplines, and even real estate investments. Many entrepreneurial providers in New York have also been making investments in, purchasing, or developing from inception, Article 28 Facilities (named after the Article in the Public Health Law which gave birth to it) such as Ambulatory Surgery Centers and Diagnostic and Treatment Centers as alternative ways of generating additional revenue and diversifying their practices.



One significant benefit to investing in or owning an Ambulatory Surgery Center or a Diagnostic and Treatment Center arises from opportunities to enjoy significantly increased reimbursement rates. For example, an Ambulatory Surgery Center is entitled to a facility fee or a technical fee when a surgical procedure is performed on-site. Similarly, a Diagnostic and Treatment Center may be entitled to a higher reimbursement rate from Medicaid or from third party payers. However, it is important to note that Medicaid Managed Care has reduced reimbursement rates for Medicaid enrollees who participate in Medicaid Managed Care. Another significant benefit is that one need not be a licensed provider to invest in or own an Article 28 facility and may share in the profits of the facility without violating New York's fee splitting or corporate practice of medicine laws.

Article 28 of the Public Health Law creates authority for the investment in, purchase of, or establishment of Ambulatory Surgery Centers and Diagnostic and Treatment Centers, as well as general hospitals, public health centers, nursing homes, dental clinics and rehabilitation centers (collectively, "Article 28 Facilities"). The New York State Public Health Council, an adminis-

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THIS ISSUE:

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Top Ten Mistakes that can lead to Professional Misconduct Charges

1. Engaging in negligent medical practice.

2. Improper alteration of the medical record of a patient.

3. Engaging in an improper relationship with a patient.

4. Keeping poor records that fail to accurately reflect thorough treatment of the patient.

5. Failing to take advantage of available impairment programs to assist with substance abuse or other impairment issues.

6. Being convicted of a criminal act, whether or not related to the practice of medicine.

7. Failing to disclose adverse information on credentialing applications.

8. Writing prescriptions for friends and relatives with whom they do not have a physician-patient relationship.

9. False or misleading advertising.

10. Failing to consult with experienced healthcare counsel after notice of a pending investigation.

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is published periodically for the medical community by Rivkin Radler LLP.

If you'd like to see a specific topic addressed in an upcoming issue, please contact us:

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COVER STORY:

Doors may be closing on opportunities relating to Ambulatory Surgery and Diagnostic Treatment Centers

continued

trative body within the New York State Department of Health, has authority over Article 28 Facilities.

In order to purchase, invest in (subject to certain limitations) or establish a new Article 28 Facility, the applicant must submit a Certificate of Need Application ("CON Application") to the Public Health Council. In addition, Article 28 requires the submission of a CON Application for capital projects relating to existing Article 28 Facilities. The CON Application focuses on three primary issues including the public need for the facility, the financial wherewithal of the proposed operator and the character and competency of the proposed operator, shareholders, directors, etc.

> ***"Another significant benefit is that one need not be a licensed provider to invest in or own an Article 28 facility..."***

The threshold issue that an applicant for a new Article 28 Facility must overcome relates to the public need for the new Article 28 Facility in the community. In determining the question of "need", the Public Health Council will consider factors such as the existence and size of other Article 28 Facilities in the service area, the services that they provide, and the affected population. It will also consider the impact that the new facility may have on the existing facilities in the service area. Specifically, the Public Health Council provides existing Article 28 Facilities that may be impacted by a new facility an opportunity to object to the CON Application.

In some instances, new applicants have decided to establish joint ventures with existing Article 28 Facilities as a way to address an objection by a neighboring facility. These joint ventures primarily exist between physicians and hospitals in connection with the establishment of Ambulatory Surgery Centers. Review of recent joint venture CON Applications reveal that the hospitals are taking an ownership interest in the proposed facility.

However, inquiry into "need" may become more complicated as the Commission on Health Care Facilities in the 21st Century (the "Hospital Restructuring Commission") considers state-wide hospital and nursing home restructuring, which may potentially include closures of existing facilities and/or a moratorium on new facilities. The Hospital Restructuring Commission was established as part of the 2005-2006 New York State Budget. In considering hospital and nursing home restructuring, the Hospital Restructuring Commission will analyze certain factors, among others, such as the need for inpatient and nursing home services in a community, the impact on potential closures on the healthcare services and economy in that area and the costs associated with such closures. The Hospital Restructuring Commission will submit its recommendations to the Governor and the State Legislature on December 1, 2006. However, it is not anticipated that its recommendations, if accepted by the Governor and the Legislature, will be implemented by the Commissioner of Health until at least June of 2008.

In this interim period, the Hospital Restructuring Commission has asked the Department of Health to hold-off on approval of proposed projects that add additional services, especially additional beds, until it has completed its

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Misidentification of Provider Numbers

BY WENDY STIMPFL

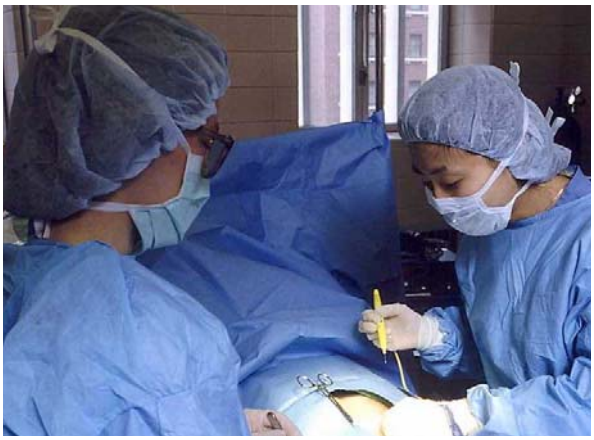
We are often asked whether a provider can bill for services under one doctor's name and identification number when another doctor actually rendered the services. This practice, whether inadvertent or intentional, is not permissible. Only the provider who examines and treats the patient can bill under his/her provider number. The common practice of a credentialed provider cosigning the records of a non-credentialed provider and then submitting the claims under his/her name is inappropriate. The name and identification number placed on the HCFA 1500 billing form must be the name and identification number of the provider who actually rendered the service to the patient.

There is no specific statute, rule or regulation addressing the use of provider numbers. However, failing to include the name and number of the provider who actually rendered service to a patient is legally problematic for the following reasons:

1. The reverse side of every HCFA 1500 form sent by a provider via mail or electronically to a third party payor contains the following certification:

"I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally performed by me or were furnished incident to my professional service by my employee under my immediate personal supervision, ... "

Thus, physicians are on notice of the "personal performance" certification on the reverse side of the HCFA 1500 form. An additional notice on the form certifies that the "foregoing information is true, accurate and complete." Misidentifying the provider who actually rendered the services could establish a civil false claims action, criminal liability, or an overpayment action, depending upon the circumstances and the provider's level of recklessness, disregard of billing rules, actual knowledge or intent.



2. The Office of Inspector General's (OIG) model compliance guidelines for physician practices clearly identify correct provider identification as a risk area. OIG's guidelines state.

> The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by OIG: Knowing misuse of provider identification numbers, which results in improper billing; an example of this is when the practice bills for a service performed by Dr. B, who has not yet been issued a Medicare provider number, using Dr. A's Medicare provider number. Physician practices need to bill using the correct Medicare provider number, even if that means delaying billing until the physician receives his/her provider number.

3. There is case law to support the policy that misidentification of a provider on the HCFA 1500 claim form is unlawful. In U.S. v. Mackby, the Court held that a physical therapy practice's placement of a physician's provider number on a HCFA 1500 claim form, where the physician did not directly render or supervise services, is a false claim subject to liability under the federal False Claims Act, even though the services were actually performed by qualified individuals. In State v. Vainio, an optometrist was convicted on two felony counts of Medicaid fraud arising from submitting claims for services that were performed by his brother. The brother was anoptometrist but was not eligible to participate in the Medicaid program. Similarly, in U.S. v. Raithatha, a physician was convicted for submitting bills to Medicare under the provider number of a physician who did not actually order the service, when the physician who performed the service was not eligible to bill Medicare.

Because commercial third party payors and some federal authorities believe provider misidentification is either a false claim or criminal fraud, practices should determine compliance with the provider identification rules. If non-compliance is evident, charts should be audited and corrective action implemented, including possibly an overpayment refund. Physicians must take seriously their obligations to correctly identify the provider who rendered the service and to refund any mistakenly obtained reimbursement. ■

Wendy Stimpfl is an associate in Rivkin Radler's Health Services Practice Group.

YOUR INPUT IS WELCOMED:

If you have a question or comment on these topics, or would like to see another topic addressed, please contact us at HealthBulletin@Rivkin.com.

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report. Specifically, at a meeting in September, members of the Hospital Restructuring Commission urged the New York State Department of Health to approve only those projects that are necessary for patient safety or which are related to downsizing.

The Hospital Restructuring Commission did consider a moratorium, but determined it does not have authority to order one. It is not clear, however, how this request will affect facilities that provide outpatient services, such as Ambulatory Surgery Centers and Diagnostic and Treatment Centers because the Hospital Restructuring Commission is focusing on inpatient facilities.

Article 28 Facilities can prove to be lucrative investments for providers and investors. Entrepreneurs and providers in New York that want to establish a new Article 28 Facility should submit applications prior to submission of the report by the Hospital Restructuring Commission to the Governor and the Legislature because the report may recommend limiting new applications or even suggest a moratorium. Similarly, those who intend on purchasing or investing in existing Article 28 Facilities should try to consummate their transactions prior to submission of the recommendations because valuations will increase if a moratorium is ultimately imposed. ■

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Mr. Manko was named to Long Island Business News' Top 40 Business People Under 40, Class of 2002. In his community, Mr. Manko is on the Board of Directors of the Long Island Power Network and is Chair of the Winthrop Pediatrics Fund for the Future, which raised more than $1.5 million for a new pediatrics pavilion. Mr. Manko is also a member of the Board of Directors of Scriptorium, Inc.

In addition to membership in the New York and California Bar Associations, Mr. Manko is also an active member of the National Health Lawyers Association, Healthcare Financial Management Association and IPA Association of America.

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For the past seven years, Ms. Stimpfl has been representing medical professionals in a variety of proceedings, including disciplinary matters before the New York State Office of Professional Medical Conduct and the New York State Office of the Professions, hospital privilege disputes, Medicare/Medicaid investigations and private carrier audits. She also counsels clients concerning the federal and state anti-kickback statutes, self-referral statutes and the federal privacy laws.