HLB
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HEALTH LAW PERSPECTIVES

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HLB Class Action on Behalf of ASCs Sparks National Confirmation of Underpayment

A class action complaint recently filed by Hooper, Lundy & Bookman, Inc. (HLB) against United Healthcare Group on behalf of non-contracted ambulatory surgery centers (ASCs) has resulted in participation from many ASCs across the country who report similar patterns of under-reimbursement. (Case No. CV09-05457-GW (PLA)).

The complaint filed in U.S. District Court charges United Healthcare Group and other health plans with misuse of the United-owned Ingenix database to knowingly under-reimburse ASCs by millions of dollars over many years.

The misuse of the Ingenix database to pay physician claims has been the subject of investigations by Congress. In its complaint, HLB alleges that the conflict of interest issues and problems with the database identified in those investigations apply equally to the calculation and payment of ASC claims.

The complaint alleges that United and other payors have systematically underpaid non-contracted ASCs. The complaint charges that flawed data in the Ingenix database, and the payors' improper manipulations of that data, are major causes of the unreasonably low amounts of reimbursement to ASCs. Since the filing, numerous ASCs across the country have confirmed extensive payment problems from Unitedís use of Ingenix.

The class action complaint sets forth a number of flaws in the Ingenix database that have led to under-reimbursement of ASCs. The complaint specifically charges that Ingenix and UnitedHealth have:

- Violated the Employee Retirement Income Security Act (ERISA) through their failure and refusal to fairly and appropriately compensate ASCs for their services.
- Violated the Racketeer Influenced and Corrupt Organizations Act (RICO) in that they have committed mail fraud and wire fraud by sending false and misleading information in connection with their scheme to underpay ASCs.
- Violated the Sherman Antitrust Act by price-fixing with regard to the reasonable and customary rates of non-contracted ASCs.
- Violated California's Business and Professions Code by engaging in unfair, unlawful and fraudulent business acts and practices.

The complaint also outlines examples of errors in the Ingenix database calculations, such as:

- Using data that is not representative of ASC charges within a geographic area;
- Improperly "scrubbing" of data so that the true rates charged by ASCs are reduced;
- Reporting of charges that are systematically skewed downward;
- Using incorrect and inaccurate methodologies to calculate Usual and Customary Rates;
- Lack of quality control to ensure the validity and authenticity of data submitted.

For more information about this case, please contact Daron Tooch or Glenn Solomon at 310.551.8111. The complaint may be viewed at http://www.healthlaw.com/about/Ingenixcomplaint.pdf.

In This Issue

HHS Issues Final Interim Privacy Breach Notification Rule

Health care providers, health plans, and their business associates under the Health Insurance Portability and Accountability Act (HIPAA) will soon be required to provide notification of security breaches of protected health information.

The "breach notification" requirement is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA).

On August 19, the U.S. Department of Health and Human Services (HHS) issued interim final regulations specifying the types of breaches requiring notification, the methods entities can use to secure data to avoid breach notification and the manner in which notices must be provided. HHS developed the regulations in coordination with the Federal Trade Commission, (FTC), which issued companion breach notification regulations that apply to vendors of personal health records and certain others not covered by HIPAA.

The HHS interim final rule requires health care providers and other HIPAA covered entities to promptly notify affected individuals of a breach, as well as the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate

The regulations define a "breach" as the "unauthorized acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information." The regulations do not define "acquisition" or "access." Breaches are considered "discovered" by a covered entity on the first day the breach is known to the covered entity "or by exercising reasonable diligence would have been known."

The regulations include three exceptions to his definition:

- disclosures in which the recipient of the information would not reasonably have been able to retain the information;
- certain unintentional acquisition, access, or use of information by employees or persons acting under the authority of a covered entity or business associate; and
- certain inadvertent disclosures among persons similarly authorized to access protected health information.

The regulations further define "unsecured protected health information" as "protected health information that is not secured through the use of a technology or methodology specified by" HHS.

To determine when information is "unsecured" and notification is required by the HHS and FTC rules, HHS also issued within the regulations an update to its guidance specifying encryption and destruction as the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals. Entities subject to the HHS and FTC regulations that secure health information as specified by the guidance through encryption or destruction are relieved from having to notify in the event of a breach of such information. According to HHS, this guidance will be updated annually.

Regarding preemption of state privacy requirements, covered entities and business associates are expected to follow the federal regulations, as well as any state regulations that are more stringent.

The HHS interim final regulations are effective September 23, 2009 but will not be enforced against entities until February 22, 2010. Comments on the interim rule are due on or before October 23, 2009. The regulations may be viewed at: http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf.

For more information, please sign-up for our webinar (details in this issue) or contact Stephen Phillips in San Francisco at 415.875.8508, Hope Levy-Biehl in Los Angeles at 310.551.8140 or Jennifer Hansen in San Diego at 619.744.7310.

Health Law Perspectives Introduces Electronic Version

To our valued subscribers:

Beginning with the November 2009 issue, Health Law Perspectives will be available in electronic format. In order to ensure that you receive the electronic version of the newsletter, please email Baron Kishimoto at bkishimoto@health-law.com. In your email, please place "email HLP" in the subject line and include your name and the name of your organization.

Many thanks for helping us with our efforts to be environmentally responsible.

HLB Challenges Blue Cross' Payments To Non-Contracted Hospitals

As more hospitals are refusing to accept the low rates and onerous terms imposed by health plans in their contracts with hospitals, the rates paid by health plans to non-contracted providers are becoming increasingly important. HLB recently filed lawsuits in federal and state courts alleging that the data and systems used by Blue Cross of California and Anthem Blue Cross Life & Health Insurance for reimbursing out-of-network services is faulty. As a result, the rates paid for these services by Blue Cross' HMO, PPO, and Blue Card members, and to beneficiaries of self-insured plans that are administered by Blue Cross, have been woefully inadequate.

The cases, filed on behalf of Methodist Hospital of Southern California, charge that Blue Cross has repeatedly underpaid Methodist Hospital for emergency and post-stabilization claims submitted after Methodist's contract terminated in December 2007. The complaint charges that the underpayments are in great part the result of flawed internal data and payment systems Blue Cross uses to determine out-of-network reimbursement rates.

The complaints allege that Methodist Hospital's charges are comparatively low, and are reasonable for the market, especially given the high quality of services that the hospital has provided. Moreover, the complaint alleges that, after the patients' emergency condition was stabilized, Blue Cross voluntarily chose not to transfer the patients to in-network facilities, yet paid Methodist Hospital's claims as though the patients had chosen to have their care continue at a non-contracted facility. The complaint explains that Blue Cross and the other payors are required to reimburse at the hospital's full billed charges in such cases, and cannot punish the hospital or the members for Blue Cross' own decision to not transfer the patients.

The California complaint specifically charges Blue Cross with:

- Failure to properly and adequately compensate Methodist Hospital for non-contracted services by using a flawed database and/or improperly manipulating the data.
- Having a conflict of interest in owning a database that is represented as objectively reflecting rates charged by hospitals and then improperly manipulating the data to purposely underpay non-contracted claims.
- Voluntarily choosing to authorize post-stabilization care and continuity of care at Methodist, but refusing to pay the hospital's customary charges for services.
- Failing to reimburse Methodist adequately for emergency and post-stabilization care services.
- Misrepresenting to Blue Cross members and Methodist the facts relating to insurance provisions, such as representing that the patient had chosen the out-of-network hospital, and therefore would be responsible for additional charges, when the patients did not choose their emergency hospital, and when Blue Cross authorized Methodist to continue with the post-stabilization care.
- Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims.

The federal complaint makes similar allegations with respect to Blue Card and self-insured plans, and also includes charges that the defendants have violated ERISA and the Racketeer Influenced and Corrupt Organizations Act (RICO).

For additional information, please contact Daron Tooch or Glenn Solomon at 310.551.8111. A copy of the complaint is available at http://www.health-law.com/about/news.shtml#methodist.

HLB'S PRIVACY WEBINAR: IS YOUR ORGANIZATION PREPARED?

Important updates on the new HIPAA Breach Notification Rule and FTC Red Flags Rule

Wednesday, September 30, 2009 ♦ 12:00 – 1:15 PST

Register at: http://www.health-law.com/Privacy

Please join Hooper, Lundy & Bookman, Inc. for an interactive webinar to help health care providers prepare for the new HIPAA breach notification rule, effective September 24, 2009 and enforceable **February 22, 2010;** and the FTC's Red Flags Rule, effective NOW and enforceable **November 1, 2009**.

Featured Presenters: Stephen K. Phillips & Tracy A. Jessner

> The cost of this webinar is $75 per connection.

> For more information on the seminar and speakers, and to register, please go to http://www.health-law.com/Privacy

> Registration questions? Contact Baron Kishimoto at bkishimoto@health-law.com.

CALENDAR

Sept.	**10**	**AHCA Webinar.** Mark Reagan presents *MIC Audits Are Here – Are You Ready?*
	15	**Medicare RAC Summit, Washington, D.C.** Mark Reagan presents *Successful Defense and Appeal Strategies.*
	16	**ExL Pharma Medical Science Liaison Best Practice Conference, San Diego.** Jennifer Hansen and Joseph LaMagna co-present a preconference workshop: *Legal Perspectives on the Regulatory Landscape*
Oct.	**1**	**L.A. County Bar Assn. 6th Annual Healthcare Law Compliance Symposium, Los Angeles.** Charles Oppenheim co-presents *Stark Law Update for Hospital and Physician Arrangements.*
	5	**NASL Annual Meeting, Chicago.** Mark Reagan presents *Update on CMS Recovery Audit Contractor (RAC) Program.*
	6	**AHLA Annual Fraud & Compliance Forum, Baltimore.** Patric Hooper presents *Hot Topics in Federal False Claims Act Cases.*
	6	**AHCA National Convention, Palm Springs, CA.** Mark Reagan presents *New Reimbursement Review Entities.*
	15	**AHLA Life Sciences Institute, Washington, D.C.** Stephen Phillips speaks on *HITECH and HIPAA.*
Nov.	**6**	**CCLA Annual Meeting, Newport Beach, CA.** Patric Hooper speaks on *Current Laboratory Issues.*
	11	**CAHF Annual Convention, Palm Springs, CA.** Mark Reagan presents *The Changing Landscape of Transfer/Discharge Hearings – From DPH to DHCS.*

HLB

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