Auto Fraud Bill May Change Facility Ownership

An auto insurance fraud bill recently signed by Governor Davis also expands sanctions for physicians committing fraud and could threaten the ownership rights of a number of types of health facilities, according to HLB Principal Lloyd Bookman.

While much of SB 1988 by Senator Jackie Speier (D-San Francisco) addresses automotive repair issues, the bill also requires a 10-year license revocation for physicians and chiropractors who are convicted of certain types of insurance fraud for a second time. In addition, the bill requires licensing boards to investigate licensees if a criminal complaint alleging insurance fraud is filed with the court.

In what came as a surprise to many health facility operators, the bill also restricts ownership of certain medical facilities to licensed physicians and surgeons, because, according to Speier's office, medical fraud mills are usually run by people who are not licensed physicians. The bill specifically states that:

“Any type of business organization that holds itself out to the public as an organization practicing medicine or that a reasonably informed person would believe is engaged in the practice of medicine shall be owned and operated only by one or more licensed physicians and surgeons.” Exceptions to this requirement are hospitals and private, nonprofit medical clinics. The director of the Department of Health Services (DHS) may also exempt other business organizations from the ownership requirements if she finds that it is in the public interest to provide the exemption.

Any physician who knowingly practices medicine with a business organization that does not meet the above requirements, however, will have her or his license to practice permanently revoked.

In a signing message accompanying SB 1988, Davis ordered DHS to take immediate action to protect medical groups.

“I am concerned that these far reaching mandates could have severe consequences for the health care system because organizations such as medical groups could be required to cease operating or their physician members could lose their licenses,” he said. Davis directed DHS to immediately issue an across-the-board waiver for any professional corporation that meets the ownership and management requirements of Section 13401.5 of the Corporations Code.

Even with the exceptions in the bill and the governor's directive, however, a whole host of health care organizations that provide services which might be construed as providing medical services are not covered, Mr. Bookman noted.

“Two examples that come to mind are drug treatment facilities and for-profit ambulatory surgical centers,” he said. “And what about medical corporations
that are 51 percent owned by physicians, with the remaining 49 percent owned by other licensed health care professionals? Will they now require 100 percent physician ownership?"

When contacted regarding waivers for such facilities, DHS representatives said they would begin considering exemptions once the bill takes effect January 1, 2001.

For more information, contact Mr. Bookman at (310) 551-8185.

HCFA Delays Provider-Based Designation Rules

The Health Care Financing Administration (HCFA) recently announced that it is delaying the implementation date of the provider-based designation portion of regulations implementing the new prospective payment system for hospital outpatient services, which had been scheduled to go into effect October 10.

The provider-based designation portion of the April 2000 final rule will now go into effect January 10, 2001, and will be applicable to individual providers with their first cost reporting period beginning on or after that date.

The regulations establish requirements that facilities must meet in order to have clinics, home health agencies and other programs treated as provider-based for purposes of Medicare reimbursement.

In announcing the delay, HCFA officials noted that after completing a number of training activities with hospitals and assembling a list of answers to frequently asked questions, “it has become apparent” that additional guidance in interpreting the regulations and addressing the procedural and administrative concerns of hospitals is needed.

To date, HCFA has not resolved a number of important issues regarding the regulations, according to HLB Principal, David Henninger.

“One of the most significant issues that remains unresolved is which units of a hospital are required to obtain provider-based designation,” he said. “The regulations are very broad and extend to both inpatient and outpatient departments. Consequently, we are unable to determine, for example, if such essential hospital departments as anesthesiology and radiology will be required to obtain designation.”

In addition, Mr. Henninger noted, it is unclear whether units that have been traditionally treated as provider-based, but which had never been formally designated as provider-based by HCFA, will be required to obtain designation. “This is a real gray area,” he said. “It appears that when drafting the regulations, HCFA believed that most provider-based entities had previously been designated as such,” he said. “In reality, they have not. Designations have historically only been made on a case-by-case basis, and only for a relatively small number of entities.”

Also troublesome, he said, is the fact that the regulations provide that, once the rule is in effect for a provider, the provider may not bill until so designated by HCFA. However, there is no application form available yet, so facilities must devise their own, he noted. In addition, the requirements for designation are quite difficult to demonstrate, in some cases requiring complex data analysis.

Given the remaining ambiguities, a prudent approach for hospitals to take is to prepare a request for provider-based designation for at least any off-campus programs, and for any entity, be it inpatient or outpatient, that is overseen by an outside manager, Mr. Henninger advised.

For more information, contact Mr. Henninger at (310) 551-8177.

OIG Issues Final Physician Compliance Guidance

The Health and Human Services Office of Inspector General (OIG) has issued its final guidance devised to help physicians in individual and small group practices design voluntary compliance programs. The guidance includes a number of changes from the original proposal, perhaps most notably the emphasis that the guidance is voluntary. In addition, it resolves some conflict of interest ambiguities that arise when office managers are also designated as compliance officers.

Unlike other guidances previously issued by the OIG for other segments of the industry, this final physician guidance does not suggest that physician practices implement all of the standard components of a full-scale compliance
program. While the components provide a solid basis upon which a physician practice can create a compliance program, OIG acknowledged that full implementation of all components may not be feasible for smaller physician practices.

As a result, the guidance emphasizes a step-by-step approach for those practices to follow in developing and implementing a voluntary compliance program. As a first step, physician practices are counseled to begin by identifying risk areas which, based on a practice’s specific history with billing problems and other compliance issues, might benefit from closer scrutiny and corrective/educational measures.

The final guidance emphasizes a number of compliance risk areas, including proper coding and billing; ensuring that services are reasonable and necessary, proper documentation; and avoiding improper inducements, kickbacks and self-referrals.

While recognizing that compliance programs may be costly for small physician practices, they could offer savings in the long run should an audit uncover problems, according to HLB Principal David Henninger.

“If HCFA uncovers problems during an audit, and you don’t have a compliance plan in place, you may be viewed as not just careless, but as engaging in deliberate ignorance or knowing disregard of the rules,” he said. “On the other hand, if you have a compliance plan in place, HCFA may just collect the amount incorrectly paid,” he said. “We have also had clients avoid the imposition of mandatory corporate integrity agreements because they had a compliance plan in place. While they were required to beef-up their plan, they were able to avoid the nightmare of implementing the onerous administrative requirements which are typical of CIAs.”

The final physician guidance is available on the OIG Web site at http://www.dhhs.gov/progorg/oig/new.html.

For more information, contact Mr. Henninger at 310-551-8177.

HCFA Issues Medicare Clinical Trial Decision

In response to an executive memorandum issued by President Clinton, the Health Care Financing Administration has issued a Final National Coverage Decision providing for Medicare coverage of certain clinical trials.

The decision establishes the costs that will be covered by Medicare and the criteria that must be met in order for services rendered to study participants to qualify for Medicare coverage.

Specifically, Medicare will cover the costs of routine items and services provided on or after September 19, 2000, to Medicare beneficiaries enrolled in qualifying clinical trials and the costs of reasonable and necessary items and services provided to diagnose and treat complications arising from a beneficiary’s participation in a clinical trial.

Routine costs of a qualifying clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries. Such items and services are covered when provided to beneficiaries enrolled in either the experimental or the control group of a qualifying clinical trial.

In view of the decision, health care organizations may be required to revise contracts that they currently have in place with trial sponsors.

For more information, contact David Vukadinovich at (310) 551-8191.

Fraud and Abuse Defense Seminar Slated

Novel strategies for defending overzealous health care fraud investigations and prosecutions will be the topic of a half-day seminar sponsored by Hooper, Lundy & Bookman, Inc. and California Health Law Monitor.

Health law experts, including former federal and state prosecutors will lead discussions on the evolving nature of health care fraud investigations and prosecutions. Topics to be discussed include:

→ Using civil rights laws to protect the rights of health care providers.
→ Challenging enforcement agencies in administrative and civil proceedings as a preemptive strategy.
→ Developing global strategies for defending prosecutions by multiple federal and state agencies.
→ Protecting providers’ rights against improper searches or demands for documents. The seminar will be held November 28 at the Westin Los Angeles Airport. Monitor subscribers each receive one free admission. The registration fee for non-subscribers is $50. To register, or for more information, contact Sharon Lee, Patric Hooper or Daron Tooch at (310) 551-8111.
## Calendar

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<td>November 3</td>
<td>HLB Attorney Robert Lundy chairs California Society of Healthcare Attorneys fall seminar at the Sheraton Gateway, San Francisco. HLB Attorney Angela Mickelson participates on a panel on Managed Care and Capitation. Featured speaker: Daniel Zingale, director of the Department of Managed Care.</td>
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<td>10</td>
<td>HLB Attorneys Patric Hooper and Bradley Tully speak on fraud and abuse at the California Clinical Lab Association annual conference, Newport Beach.</td>
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<tr>
<td>28</td>
<td>HLB and <em>California Health Law Monitor</em> present a seminar on “Novel Strategies for Defending Overzealous Health Care Investigations and Prosecutions” at the Westin Los Angeles Airport.</td>
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