Health Care Alert – November 2008

The field of health law is a constantly evolving system of rules and regulations which have a great impact on all involved in the business of Healthcare. Abrams Fensterman is dedicated to keeping not only ourselves up-to-date on the most recent changes, but also our friends and clients. We would like to take this opportunity to inform all of you of several new developments which may affect your healthcare practice.

FTC EXTENDS "RED FLAG" RULES TO HEALTHCARE PROVIDERS, BUT DELAYS IMPLEMENTATION DATE TO MAY 1, 2009

The Federal Trade Commission's Red-Flag rules are intended to prevent and mitigate identity theft. The rules require each "creditor" that holds a consumer account, or any other account for which there is a reasonably foreseeable risk of identity theft, to develop and implement an Identity Theft Prevention Program. The program must be able to combat identity theft in connection with both new and existing accounts. **The FTC has recently taken the position that healthcare providers who bill insurance companies or establish payment plans for their patients are considered "creditors" under these regulations. As such, healthcare providers need to establish appropriate compliance plans by May 1, 2009.** Penalties of $2,500 per incident can be imposed for non-compliance.

OIG MODIFIES PROVIDER SELF-DISCLOSURE PROTOCOL FOR FRAUD AND ABUSE ISSUES

The OIG Inspector General recently issued an open letter that discusses certain refinements and clarifications to the OIG's policies with regard to its Provider Self-Disclosure Protocol ("SDP"). The OIG's purpose in doing so was to increase the efficiency of the SDP and further benefit healthcare providers who self-disclose fraud and abuse that they uncover in their medical practice. The provider's initial submission must now contain certain additional information, including: (1) a complete description of the conduct being disclosed; (2) a description of the provider's internal investigation; (3) an estimate of the damages to the Federal health care programs and the methodology used to calculate that figure; and (4) a statement of the laws potentially violated by the conduct. The provider must be in a position to complete the investigation and damages assessment within 3 months after acceptance into the SDP. Providers will be removed from the SDP at the discretion of the OIG unless they disclose in good faith and are timely with their responses.

OIG EXPRESSES CONCERN OVER JOINT VENTURE INVOLVING SPACE, EQUIPMENT, AND PERSONNEL SHARING AMONG REFERRING PHYSICIANS

The OIG recently released an Advisory Opinion regarding a proposal whereby one medical group would provide space, equipment and personnel to other medical groups through block leases. The OIG has longstanding concerns about certain "problematic" joint ventures, especially when all or most of the business of the joint venture is derived from one of the joint venturers. Under the proposed arrangement, the groups that would be acquiring access to the other group's space, equipment, and personnel would be expanding into a related line of business, which the OIG felt was dependent on patient referrals. The

business generated by the groups under contract would be more than sufficient to meet the fair market value rental amount under the space, equipment and personnel-“sharing agreement”, thus eliminating any real business risk to the groups acquiring access to such space, equipment, and personnel. The OIG was unable to rule out the possibility that the parties’ contractual relationship is designed to permit one party to do indirectly what it cannot do directly; this is, to pay the other party for its referrals. The OIG feels that such an arrangement is an inherently suspect contractual joint venture and could potentially generate prohibited remuneration under the anti-kickback statute.

PHYSICIAN NOT EMPLOYED BY HOSPITAL STILL ALLOWED TO SUE FOR DISCRIMINATION

An appellate court recently held that in certain circumstances, a physician does not have to be a hospital employee to sue for discrimination under Title VII of the Federal Civil Rights Law. The court held that certain factors influence any inquiry in this regard including whether the non-employed physician receives any remuneration from the hospital and also 13 other useful factors, including: “[1] the hiring party’s right to control the manner and means by which the product is accomplished[;] …. [2] the skill required; [3] the source of the instrumentalities and tools; [4] the location of the work; [5] the duration of the relationship between the parties; [6] whether the hiring party has the right to assign additional projects to the hired party; [7] the extent of the hired party’s discretion over when and how long to work; [8] the method of payment; [9] the hired party’s role in hiring and paying assistants; [10] whether the work is part of the regular business of the hiring party; [11] whether the hiring party is in business; [12] the provision of employee benefits; [13] and the tax treatment of the hired party.” The court in this case said that because of the Hospital’s enforcement of rules involving medical procedures and disciplining doctors, the hospital effectively took on the role of an employer and as such, became subject to Title VII compliance.

DOCTOR HELD LIABLE FOR FAILING TO PROVIDE INTERPRETIVE SERVICES TO DEAF PATIENT

A jury recently awarded $400,000 to a deaf patient who had been repeatedly denied a sign language interpreter by her rheumatologist while undergoing treatment for lupus. The attorney who represented the patient labeled this “the largest award of its kind in the United States” and said “The only reason there aren’t more suits is because of the language barrier that keeps the deaf from using the legal system”. Healthcare providers are reminded of their obligation to provide interpretative services to deaf patients under the Federal Americans With Disabilities Law.

NYS COURT OF APPEALS CONFIRMS 30-DAY RULE FOR NO-FAULT CLAIMS

The New York State Court of Appeals recently re-affirmed the validity of the “30-day rule” in no-fault insurance cases. The “30 day rule” provides that a carrier must raise an affirmative ground for its denial of a claim within 30 days of its receipt. If it does not, all of the carrier’s claims, even otherwise legitimate claims, will be barred by the 30-day rule. This holds true even in a case where there is outright billing fraud. The two exceptions to the 30-day rule are “coverage” issues and staged accidents, which are affirmative defenses that can be raised at any point in the litigation.

For more information on any of the information discussed above, please contact the law offices of Abrams Fensterman at 516-328-2300.