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Health -E- News

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SECTION NEWS

Tentative Date for CDC Training

David Johnson has arranged with the State Bar (Rob Koonce) for a half day training session on emergency preparedness for Friday, Oct 14, 2005. CLE will be available at a cost of \$79 (\$39 if no CLE) to cover refreshments, cost of room, etc. Please direct any questions regarding the date and time (morning or afternoon) including whether you plan to attend to David Johnson. dhjohnso@rodey.com

NEW DEVELOPMENTS IN HEALTH LAW

US Attorney Forms Unit Dedicated to Health Care Fraud Prosecution

The U.S. Attorney for the Central District of California, Debra W. Yang, who serves on the Attorney General's Advisory Committee Working Group on Health Care Fraud, has established a new Health Care Fraud Unit "to enhance efforts to criminally prosecute health care fraud" in Southern California. In a press release, Yang stated: "I have formed a new criminal unit that is dedicated to the prosecution of health care fraud, which is unfortunately one of the big 'growth areas' of crime in our district. The arrest of Mr. Okorn is just the opening salvo in our stepped-up efforts to tackle health care fraud in Southern California - one of the hot spots in the country for this type of fraud. There are dedicated HHS-OIG agents and FBI agents whose sole job is to help fight health care fraud. All types of health care fraud - meaning, public and private victims - will be within the purview of this new prosecution unit." For more:

<http://www.usdoj.gov/usao/cac/pr2005/022.html>

Reuters News Service

MIAMI - Florida sued Tenet Healthcare Corp. on racketeering charges, saying the embattled hospital operator inflated fees to obtain \$1 billion in improper reimbursements from a Medicare fund....[on the basis that] Tenet schemed to take more out of a special Medicare trust fund called the "Outlier Pool" than it was entitled to claim. ...Tenet artificially inflated its bills so much it raised the threshold at which all hospitals could make claims from the fund, thereby denying the other medical centers their rightful reimbursements, the lawsuit said."

The entire story may be found at <http://www.chron.com/cs/CDA/ssistory.mpl/business/3065578>

Tenet Agrees to Settle Pricing Class Action Lawsuits

On March 10, Tenet Healthcare Corporation (NYSE: THC) announced that it has reached an agreement providing for a nationwide settlement of certain class action lawsuits regarding prices that uninsured and some under-insured patients were charged for prescription drugs and other medical products and services at hospitals owned and operated by Tenet subsidiaries.

For more: <http://www.tenethealth.com/TenetHealth/PressCenter/PressReleases/TenetPricingClassActionSettlement.htm>

HIPAA

DHHS OCR Posts New HIPAA FAQs

The Department of Health and Human Services (DHHS) Office for Civil Rights (OCR) has posted two new frequently asked questions (FAQs) regarding Health Insurance Portability and Accountability Act (HIPAA) requirements.

The first question involved whether a health plan may disclose protected health information (PHI) to a state child support enforcement agency in response to a National Medical Support Notice. OCR said that the HIPAA Privacy Rule allowed such disclosure pursuant to 45 C.F.R. § 164.512(f), which allows disclosure of PHI to a law enforcement official for law enforcement purposes. According to OCR, an employee "who is empowered by state or federal law to enforce a medical child support order, meets this definition of a law enforcement official." OCR said, the National Medical Support Notice must contain assurances that: "(1) the information sought is material and relevant to a legitimate law enforcement inquiry; (2) the request is specific and limited in scope; and (3) de-identified information cannot reasonably be used."

The second FAQ asked whether a covered entity must obtain an individual's authorization to disclose PHI to an interpreter. OCR said that a covered entity did not need to obtain an authorization to use an interpreter as long as the provider meets certain conditions. Under 45 C.F.R. § 164.506(c), covered entities may use and disclose PHI for treatment, payment, and healthcare operations without an individual's authorization, and use of an interpreter falls under healthcare operations, said OCR.

To read the FAQs, go to <http://www.hhs.gov/ocr/hipaa/>

The HHS Office of Inspector General Has Issued Three New Advisory Opinions.

The OIG on February 18, 2005, issued two advisory opinions (Nos. 05-05 & 05-06) approving gainsharing arrangements. These are the fifth and sixth advisory opinions this year on gainsharing. The OIG found that virtually all of the elements of these gainsharing arrangements implicated the civil monetary penalty prohibition on hospital payments to a physician to induce reductions or limitations of patient care services to Medicare or Medicaid beneficiaries under the physician's direct care (the "CMP Law"). The OIG also found that the arrangements implicated the anti-kickback law. However, in each advisory opinion, the OIG decided not to impose administrative sanctions based on the protections incorporated into the respective arrangements. Of significance, the OIG noted that it was expressing no opinion as to how, or if, gainsharing arrangements might be permitted under the Stark physician self-referral law. To read the full opinion, go to:

<http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0505.pdf>

To read Advisory Opinion 05-06 (concerning a proposed arrangement in which a hospital will share with a group of cardiac surgeons a percentage of the hospital's cost savings arising from the surgeons' implementation of a number of cost reduction measures in certain surgical procedures) go here:

<http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0506.pdf>

On February 18, 2005, the OIG also issued Advisory Opinion 05-07 (concerning an exclusive contract for ambulance services between a municipality and ambulance company that provides for an in-kind exchange of dispatch services and billing services between the parties). In this Opinion, the OIG concluded that an exclusive contract between a city and an ambulance company involving the exchange of dispatch and billing services would not be subject to administrative sanctions. Following an open, competitive bid process, the city awarded an exclusive, five

year contract to an ambulance company for emergency services. The arrangement involved an in-kind exchange of services: the city agreed to provide dispatch services (from an existing multi-city communications center) to the ambulance company; and the ambulance company agreed to provide billing and collection services to the city. The central issue was whether the ambulance company's offer to provide "free" billing and collection services to the city in exchange for an exclusive contract was potentially abusive. To read the full opinion go [here](http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0507.pdf): <http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0507.pdf>

Congress Should Extend Specialty Hospital Moratorium Pending Further Review, MedPAC Advises

Congress should extend the current moratorium on the development of new specialty hospitals through January 1, 2007, the Medicare Payment Advisory Commission (MedPAC) recommended in its latest report on the issue. MedPAC said the extension is needed to allow further study on the effect of these limited service facilities. At the same time, MedPAC also recommended changes to the way Medicare reimburses hospitals for inpatient services "to improve the accuracy of the payment system and thus reduce opportunities for hospitals to benefit from selection."

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established an eighteen-month moratorium on physician ownership of, or investment in, certain specialty hospitals like those providing orthopedic, cardiac, or surgical care. The moratorium is set to expire June 7, 2005. *Health Lawyers Weekly*, March 11, 2005. http://www.healthlawyers.org/hlw/issues/050311/MedPAC_rpt.pdf (may require subscription)

Fraud and Abuse

Federal officials announced March 3 that a federal jury in Miami, Florida convicted two more individuals on charges stemming from their involvement in a multi-million Medicare fraud and money laundering scheme. The scheme involved durable medical equipment companies that fraudulently submitted false claims to Medicare for custom-made orthotic devices, according to U.S. Attorney for the Southern District of Florida Marcos Daniel Jimenez's press release. Twelve convictions have now been made in connection with the scheme, the press release said. Stephanie Smith, who owned a medical clinic that supplied false prescriptions used in the scheme was convicted along with Miraidy Gonzalez, who worked at the billing company that created fake patient files for submission to Medicare, for conspiracy to commit healthcare fraud, said the release. Smith and Gonzalez also were convicted of conspiracy to commit money laundering. In addition, Smith was convicted on three counts of soliciting and receiving kickbacks. To read U.S. Attorney Jimenez's press release, go to <http://www.usdoj.gov/usao/fls/StephanieSmith.htm>

HEALTH LAW CASES

US v. DENTSPLY INT'L, INC., No. 03-4097 (3rd Circuit, February 24, 2005)

The United States Court of Appeals for the Third Circuit has ruled in favor of the Department of Justice (DOJ) and found that Dentsply International, Inc., a maker of artificial teeth, unlawfully monopolized in violation of Section 2 of the Sherman Act when it entered into exclusive dealing relationships with dealers of artificial teeth. The Government alleged that Defendant, Dentsply International, Inc., acted unlawfully to maintain a monopoly in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2; entered into illegal restrictive dealing agreements prohibited by Section 3 of the Clayton Act, 15 U.S.C. § 14; and used unlawful agreements in restraint of interstate trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. After a bench trial, the District Court denied the injunctive relief sought by the Government and entered judgment for defendant. To read the full text of this opinion, go to: <http://caselaw.lp.findlaw.com/data2/circs/3rd/034097p.pdf>

CHEROKEE NATION OF OKLA. v. LEAVITT, No. 02-1472 (U.S. Supreme Court, March 01, 2005)

The government's promise to pay "contract support costs" that two Indian Tribes incurred for health services that a government agency, the Indian Health Service, would otherwise have provided, is legally binding. To read the full text of this opinion, go to: <http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=US&navby=case&vol=000&invol=02-1472>

PORTLAND ADVENTIST MED. CTR. v. THOMPSON, No. 03-35612 (9th Circuit, March 02, 2005)

Medicare's Disproportionate Share Hospital statute is unambiguous and requires reimbursement to plaintiff-

hospitals for services rendered to the entire low-income population. To read the full text of this opinion, go to:
<http://caselaw.lp.findlaw.com/data2/circs/9th/0335612p.pdf>

HAUCK v. NICHOLSON, No. 04-7067 (United States Court of Appeals for the Federal Circuit, March 02, 2005)

Denial of plaintiff's claim for service connection for loss of vision is affirmed where there is no clear and unmistakable error in the decision. To read the full text of this opinion, go to:

<http://caselaw.lp.findlaw.com/data2/circs/fed/047067p.pdf>

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