



# Health -E- News

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## SECTION NEWS

### Upcoming CLEs:

April 22nd	7:30 AM	Fraud & Abuse: Federal Laws - "Update on Civil Healthcare Fraud Prosecution." The guest speaker is Howard Thomas, Assistant U.S. Attorney for New Mexico
May 27th	11:30 AM	Fraud & Abuse: HMO and DOI Enforcement Activities
June 24th	7:30 AM	Fraud & Abuse: Stark I & II and Anti-Kickback

**The April 22nd CLE will be a look at Federal civil healthcare fraud law, investigation and prosecution.**

Howard R. Thomas, Assistant United States Attorney for the District of New Mexico, will cover recent legal developments, and discuss other topics of interest. The information presented at this meeting does not necessarily represent or reflect the interpretation, position or opinion of the United States Department of Justice or of the presenter. Nothing presented at this meeting creates or diminishes any rights, obligations, benefits or privileges. Further, nothing presented at this meeting may be relied upon to create any substantive or procedural evidence, rights, claims or remedies; and, nothing presented at this meeting shall place any limitations on otherwise lawful prerogatives of the United States Department of Justice.

[Editor's Comment: Anything with a disclaimer like this just has to be good!]

**Board Meetings:** The Board will meet on the following dates at the State Bar office, and any member of the Section is welcome to attend these meetings:

May 20 <sup>th</sup>	7:30 AM
June 17 <sup>th</sup>	11:30 AM

## TEN WAYS TO GET INVOLVED IN A FRAUD AND ABUSE INVESTIGATION

The March HLS CLE, ten common reasons why health care providers get involved in fraud and abuse investigation. The next three newsletters will recap these reasons, and here are the first three:

- *Disgruntled employees* who go to law enforcement either wanting to get even, get rich (which can occur under qui tam provisions of the state and federal False Claims Acts), or get it off their chests because they believe they were involved in something illegal. Employment lawyers are becoming more sensitive to whistle blower accusations, and careful consideration needs to be given to this potential problem when advising health care clients. The new Medicaid False Claims Act has a whistleblower provision.
- *Other providers* who have various motives for reporting a peer. This is difficult to anticipate and control. The problem can arise when one provider “fills in” for another provider who takes vacation. It can arise during or after a practice breaks up.
- *Third Party Payors* whose internal investigations reveal improper billing practices. The MCOs who provide services under Salud! have a contractual obligation to identify providers who may be engaged in Medicaid Fraud, and/or to terminate their contracts or report them to law enforcement officials. Software programs have been developed which can take utilization review (UR) data and analyze it, and determine when a provider’s billing practices fall outside certain pre-defined parameters. This does not mean that the provider is engaged in fraud, anymore than the IRS determining that tax payors deductions may not fit some predefined pattern. It can, however, result in an investigation, just as excessive deductions can result in an IRS audit. This may currently be the most active arena for fraud and abuse enforcement activity.

The Health Law Section’s CLE in May will address this aspect of private enforcement, as well as the Department of Insurance’s efforts to curtail fraud in the commercial insurance industry.

In the next newsletter, we will discuss targeted programs, scams reported by patients and third parties, and bad advice from commercial transactional lawyers.

### NEW DEVELOPMENTS IN HEALTH LAW

#### OIG Posts Special Alert To Physicians About Concierge-Type Services

In Issue 9 we reported that the Department of Health and Human Services Office of Inspector General (OIG) issued March 31 an Alert reminding physicians participating in Medicare that they may not charge Medicare.

To see the actual alert, go to:

<http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>

#### DOL Determines HSAs Are Not Employee Welfare Benefit Plans

The Department of Labor (DOL) has determined that health savings accounts (HSAs) are not employee welfare benefit plans covered by the Employee Retirement Income Security Act (ERISA). DOL Field Assistance Bulletin 2004-1, which was released on April 7, was issued in response to questions by employers about whether HSAs are ERISA-covered employee welfare benefit plans. The Medicare Prescription Drug, Improvement, and Modernization Act added a section to the Internal Revenue Code

to establish HSAs, which allows eligible individuals to contribute to the accounts on a tax-free basis funds that are used for paying qualified medical expenses. DOL specifically said that HSAs meeting the conditions of the safe harbor for group or group-type insurance programs under 29 C.F.R. Section 2510.3-1(j)(1)-(4) would not be employee welfare benefit plans under ERISA.

To read DOL Field Assistance Bulletin 2004-1, go to [http://www.dol.gov/ebsa/regs/fab\\_2004-1.html](http://www.dol.gov/ebsa/regs/fab_2004-1.html)  
{Editor's Note: HSA's (formerly known as Medical Savings Accounts – MSAs) have been beefed up and may provide many small to medium sized NM employers with a viable option to reduce health care benefit expense, particularly those who have Cafeteria Plans in place. The fact that these plans are not covered by ERISA is both good news and bad news. They may become the subject of state regulation, and claims brought against employers will not be pre-empted. Nevertheless, this is a subject that both healthcare lawyers and employee benefit lawyers should explore and watch carefully].

### **OIG Issues Guidance For Medicare-Endorsed Discount Drug Card Sponsors**

The Department of Health and Human Services Office of Inspector General (OIG) April 9 issued guidance on the application of its fraud and abuse authorities to proposals of Medicare-endorsed discount drug card sponsors to pay network pharmacies for certain education and outreach efforts, including enrollment assistance. While the OIG said it supports bona fide efforts to educate Medicare beneficiaries about the discount drug card program, it noted that payment arrangements between card sponsors and network pharmacies for education and outreach services could implicate the Anti-Kickback Statute. According to the guidance, the OIG's "chief concern in this context is that financial incentives could distort or inhibit the flow of information to beneficiaries and, thereby, convert the education process into a mechanism for steering beneficiaries to a particular drug card without regard to the beneficiaries' best interest."

To read the guidance, go to  
[http://www.healthlawyers.org/docs/ask2004/OIG\\_guidance.pdf](http://www.healthlawyers.org/docs/ask2004/OIG_guidance.pdf)

[Editor's Note: While the current administration touts the Medicaid drug discount card program, those who would like to have their candidate reside in the White House next year are attacking it. Sorting out the truth from the friction in what is becoming more of a partisan fight than an objective legal analysis, is becoming more difficult. The fraud and abuse implications of the educational programs will raise the ante in this battle for the hearts and minds of the elderly voter.]

### **NEW CASES**

WOODSTOCK CARE CTR. v. THOMPSON, No. 01-3889 (6th Circuit, April 02, 2004)  
Long-term care facility unsuccessfully appeals the Civil Monetary Penalty imposed by defendant. Numerous incidents of residents escaping from the facility or assaulting other residents were sufficient to support the finding of immediate jeopardy to the residents in violation of 42 C.F.R. section 483.25.

To read the full text of this opinion, go to:  
<http://laws.lp.findlaw.com/6th/04a0095p.html>

PHARM. RESEARCH & MFRS. OF AM. v. THOMPSON, No. 03-5117, 03-5118  
(U.S. District of Columbia Circuit Court of Appeals, April 02, 2004)  
Various challenges to the "Michigan Best Practices Initiative," a low-cost state prescription drug coverage program, were properly rejected.

To read the full text of this opinion, go to:  
<http://caselaw.lp.findlaw.com/data2/circs/dc/035117a.pdf>

SHAW v. MCFARLAND CLINIC, P.C., No. 02-3897, 03-1167 (8th Circuit, April 05, 2004)

An employee's action alleging the improper denial of preauthorization of health benefits by her employer is most analogous under Iowa law to an action for breach of a written contract, thus a ten-year statute of limitations applies. Summary judgment for plaintiff-employee, improperly denied preauthorization for tissue expander reconstruction surgery, is affirmed. [Editor's Comment: NM's statute on written contracts is six years]

To read the full text of this opinion, go to:  
<http://caselaw.lp.findlaw.com/data2/circs/8th/023897p.pdf>

STRATTON v. E.I. DUPONT DE NEMOURS & CO., No. 03-2609 (3rd Circuit, April 07, 2004)

Denial of health insurance coverage to plaintiff, who underwent arthroplasty surgery to treat her TMJ instead of other, less invasive procedures, was not an abuse of discretion.

To read the full text of this opinion, go to:  
<http://caselaw.lp.findlaw.com/data2/circs/3rd/032609p.pdf>

WITTY v. DELTA AIR LINES, INC., No. 03-30654 (5th Circuit, April 13, 2004)

Passenger who allegedly developed Deep Vein Thrombosis on one of defendant's flights raises state tort claims that are preempted by federal law. Any requirement increasing leg room would "relate to price" and is thus preempted by the ADA; any state law regarding safety warnings that airlines must give passengers is preempted. Judgment is rendered for defendant.

To read the full text of this opinion, go to:  
<http://caselaw.findlaw.com/data2/circs/5th/0330654cv0p.pdf>

UNIVERSAL HEALTH SERVS. INC. v. THOMPSON, No. 02-56611 (9th Circuit, April 13, 2004)

Contentions that defendant committed four methodological errors in setting the 1991-1996 thresholds for "outlier payments," by which hospitals are reimbursed for patients with abnormally high costs, were properly found to have been waived by plaintiffs' failure to raise them in the annual notice-and-comment rulemakings before defendant.

To read the full text of this opinion, go to:  
<http://caselaw.lp.findlaw.com/data2/circs/9th/0256611p.pdf>

MEADOWWOOD NURSING HOME v. US DEP'T OF HEALTH & HUMAN SERVS., No. 02-4115 (6th Circuit, April 15, 2004)

Substantial evidence supports the finding that certain beds in petitioner's facility were unsafe; imposition of civil monetary penalties under 42 C.F.R. section 483.25(h)(1) is affirmed.

To read the full text of this opinion, go to:  
<http://laws.lp.findlaw.com/6th/04a0107p.html>

PROVIDENT LIFE & ACCIDENT INS. CO. v. SHARPLESS, No. 03-30566 (5th Circuit, April 12, 2004)

Anesthesiologist was properly found to have made material, fraudulent misstatements in her ERISA-governed disability policy application; as this made the policy retroactively void by its own terms, plaintiff's action was for rescission of the contract and was thus an equitable action, authorized by ERISA, to which there is no right to a jury trial.

To read the full text of this opinion, go to:

<http://caselaw.lp.findlaw.com/data2/circs/5th/0330566cv0p.pdf>

CARR v. RELIANCE STANDARD LIFE INS. CO., No. 02-2377 (6th Circuit, April 14, 2004)

Denial of plaintiff's claim for long-term disability benefits was not arbitrary or capricious. Since he returned to work part-time during the Elimination Period, his situation falls squarely within the plan's definition of "Partial Disability."

To read the full text of this opinion, go to:

<http://laws.lp.findlaw.com/6th/04a0103p.html>

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