



Health -E- News

SECTION NEWS

Section Board

Jennifer Stone
(Chair)
505-842-1950
jstone@mstlaw.com

John Bannerman
(Chair Elect.)
505-837-1900
jab@NMCounsel.com

Susan Sullivan
505-827-2962
ssulliva@doh.state.nm.us

Charles Gurd
505-856-1468
cgurd@aol.com

Diane Garrity
505-983-6956
dgarrity@sgmnlaw.com

W. Ann Maggiore
505-844-0777
wamaggiore@btblaw.com

Caralyn Banks
505-524-9617
clbanks@reeveslaw.com

Barbara Quissel
505-816-4224
Barbara-
Quissell@bcbsnm.com

Gabe Parra
505-923-6505
gparra@phs.org

Kathleen Hessler
(Past Chair)
505-828-1150
khessler@worldnet.att.net

Brenda Maloney
(YDL)
505-765-5900
bmmaloney@rodey.com

Upcoming CLEs:

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

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 th	7:30 AM
June 17 th	11:30 AM

NEW DEVELOPMENTS IN HEALTH LAW

Three More Ways to Become Involved in a Fraud & Abuse Investigation.

The last newsletter identified disgruntled employees, other providers, and third party payors as reasons health care practitioners can become embroiled in a fraud and abuse investigation. Here are three more:

- *Targeted Programs, like Medicaid Fraud Control Unit's 2003 Failure-To-Provide- Care Program.* When Medicaid officials will identify providers who are billing for an abnormal number of specific procedures, or for procedures that are unusual given the patient population. A Texas dentist was caught putting crowns on children under the age of 10 – not billing for work he didn't perform, but doing unnecessary root canals and crowns on the children, none of whom would probably ever want to go to a dentist for the rest of their lives. Health lawyers should keep informed concerning the various initiatives being planned.
- *Scams reported by patients or third parties.* One example was a senior center that was asked if it would mind if an optometrist gave free eye exams to the

residents. During the free exam the optometrist asked for a social security number and got a bunch of them. He then billed Medicaid for the services, as if they exams had been provided in his office. Medicare now prints a fraud and abuse notice on its notice of payment to patients, and the number of patients reporting incorrect billing is increasing. AARP and other consumer organizations are actively promoting the reporting of what might be illegal billing activities by providers.

- *Bad advice from commercial or transactional lawyers* who assume that certain business arrangements or practices that would be perfectly legitimate in another context are legitimate in a healthcare transaction. The *Stark* laws and their accompanying regulations, as well as state and federal *Anti-kickback* laws and regulations have imposed significant new barriers to joint ventures and many attempts to engage in the integrated delivery of certain designated health services. The laws and regulations are so pervasive, that *safe harbors* have been published to explain those arrangements that will not violate the laws. Every transaction involving physician ownership, control or participation in business enterprise involving the designated health services, should be reviewed for compliance with these laws.

This topic will be discussed in detail at the June 2004 Health Law Section CLE.

AHLA Seeks Regulatory Clarifications On Healthcare Facilities' Efforts To Assist Physicians With Malpractice Insurance Costs

A task force convened by the American Health Lawyers Association (AHLA) has requested joint clarification from three federal agencies on "permissible assistance that hospitals and other acute and long-term care providers may provide to physicians and other health professionals to lessen the effects of rising malpractice insurance premiums." The clarification was requested in a letter sent to Steven T. Miller, Director, Exempt Organizations branch of the Internal Revenue Service's Tax Exempt and Government Entities Division; Lewis Morris, Chief Counsel for the Inspector General, Department of Health & Human Services (DHHS); and Leslie Norwalk, Acting Deputy Administrator of DHHS' Centers for Medicare and Medicaid Services (CMS).

Senate Finance Committee Hears Testimony On Power Wheelchair Fraud, CMS Announces New Initiative To Curb Abuse

Fraud and abuse involving power wheelchairs has become a significant vulnerability for the Medicare program, DHHS Acting Principal Deputy Inspector General Dara Corrigan said in written testimony submitted to the Senate Finance Committee for an April 28 hearing. Also on April 28 CMS launched a new three-prong plan to strengthen its policies for power mobility devices that focuses on coverage, payment, and quality of suppliers. The DHHS Office of Inspector General (OIG) also released two new reports about Medicare and power wheelchairs. In the first report, "Medicare Payments for Power Wheelchairs" (OEI-03-02-00600), the OIG found that many beneficiaries did not meet the coverage criteria for a power wheelchair, particularly those with the K0011 code under which most power wheelchairs are billed. In the second report, "A Comparison of Prices for Power Wheelchairs in the Medicare Program" (OEI-03-03-00460), the OIG found that Medicare pays more for power wheelchairs than consumers or suppliers.

For more information about the Senate Finance Committee hearing and to read prepared testimony, go to <http://finance.senate.gov/sitepages/hearing042804.htm>

Medco Settles Unfair Trade Claims For Over \$29 Million

U.S. Attorney for the Eastern District of Pennsylvania Patrick L. Meehan and twenty state attorneys general announced April 26 that Medco Health Solutions, Inc. (Medco), a pharmaceutical benefits management (PBM) company, has agreed to pay over \$29 million to settle claims that Medco solicited drug switches and failed to pass the resulting savings on to patients or their health plans. Medco is the largest

PBM in the country and covers over 62 million people. The United States and the attorneys general alleged that the drug switches caused an increase in costs to health plans because the switch to another drug often resulted in the patient requiring a follow-up visit to the doctor and additional tests.

To read the consent order, go to http://www.healthlawyers.org/hlh/docs/medco_consentorder.pdf
(Note: Link will open Adobe PDF file).

Democrats Object To DHHS Response To Request For Information On Medicare Cost Estimates

In an April 26 letter to DHHS Secretary Tommy G. Thompson, Democrats on the House Government Reform Committee said the agency failed to adequately satisfy their request for information about the administration's estimate placing the cost of the new Medicare law at \$534 billion over ten years, a figure substantially higher than the \$395 billion estimate projected by the Congressional Budget Office. In the letter, the lawmakers said they are expanding their request to include all communications relating to the cost of the Medicare law between any executive branch official and any member of the conference committee, any member of the House or Senate leadership, and any staff working for these members. The lawmakers urge DHHS to provide their response by May 10, 2004.

To read DHHS' April 16 response to the request, go to http://www.healthlawyers.org/hlh/docs/medicarecost_DHHS_response.pdf

CMS Publishes Final Rule Eliminating Statement Of Intent Procedures

CMS published in the April 23 Federal Register (69 Fed. Reg. 21963) a final rule removing the written statement of intent (SOI) procedures that extended the time for filing a Medicare claim by six months. The absence of the SOI means that providers, suppliers, and beneficiaries will have from fifteen to twenty-seven months to file claims with Medicare contractors. CMS believes the states are using the SOI procedures for "paying and chasing" instead of following required cost-avoidance procedures. Many states pay the claim knowing there is Medicare liability, and then use the SOI procedures to extend the time for filing the claim, which is not a proper cost-avoidance procedure. Because the SOI procedures are costly and are not being used for their intended purpose CMS concluded the removal of the SOI procedures would not have a significant impact on providers. The final rule is effective May 24, 2004.

To read the final rule, go to http://www.healthlawyers.org/docs/ask2004/69FR_21963.pdf
(Note: Link will open Adobe PDF file).

NEW HEALTH LAW CASES

PEDIATRIC SPECIALTY CARE, INC. v. ARKANSAS DEP'T OF HUMAN SERVS.,

No. 03-1015, 03-2616, 03-1483 (8th Circuit, April 16, 2004)

Defendant was properly enjoined from altering the Child Health Management Services program without first conducting an impact study to ensure that the changes are consistent with the principles of economy, efficiency, quality of care and access to care under the Medicaid Act. Finding that denial of services constituted a substantive due process violation is reversed without prejudice.

To read the full text of this opinion, go to:
<http://caselaw.lp.findlaw.com/data2/circs/8th/031015p.pdf>

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