

SEMINOLE COUNTY MEDICAL SOCIETY

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HOT LEGAL TOPICS

BY

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1. Grace Period Included in the Affordable Care Act Could Pose Financial Risk to Healthcare Professionals and Providers

A little known rule published by CMS to implement the Affordable Care Act could pose a significant financial risk for doctors, hospitals and other healthcare providers. The CMS rule gives individuals who purchase subsidized coverage through the exchanges a 90-day grace period before their coverage is cancelled for nonpayment. The insurance plan is required to pay any claims incurred during the first 30 days of the grace period. However, the insurance company is not required to pay the claims incurred during the last 60 days of the grace period if the individual's coverage is terminated. The insurance plan is allowed to place all the claims during the last 60 days of the grace period in a pending status.

As a physician, this means that you could provide services to an individual during the last 60 days of the grace period and never be paid by the insurer.

The rule requires the insurance plan to notify the healthcare providers when an insured individual is in the last 60 days of the grace period, but the rule does not specify how the health plan will

provide that notice to providers. The only notice some providers receive will probably be the “pending status” placed on the unpaid claims by the insurance plan.

The result could be that physicians and other healthcare providers would provide a significant amount of uncompensated care. CMS has been asked to modify the rule so that insurers are required to pay claims during the entire 90-day grace period.

2. Choosing Wisely Campaign

The Choosing Wisely Campaign is a program of the American Board of Internal Medicine Foundation designed to educate patients and physicians about tests, treatments, and procedures that are often overused, misused, or ineffective. The Choosing Wisely Campaign is designed to aid physicians and patients in discussions so that patients, with the aid of their physicians, can make intelligent choices about their care.

More than 50 medical specialty societies have developed lists of tests, treatments and procedures that physicians and patients should question. Each list includes specific tests or procedures that are overused or unnecessary based upon evidence-based medicine. The lists from all of the contributing medical specialty societies are available on the [American Board of Internal Medicine Foundation website](#).

As these lists continue to grow, we may see more qui tam/whistleblower and false claims cases based on tests and procedures that are on the lists. Qui tam cases have been brought under the federal False Claims Act for the recovery of Medicare payments from hospitals, physicians, nursing homes and other types of healthcare providers based on lack of “medical necessity.” These cases allege that false claims were submitted to the government. If a test or procedure was “medically unnecessary,” then the claim is more likely to be false.

Most states have similar false claims acts or qui tam laws providing similar causes of action and recoveries to plaintiffs in the case of Medicaid payments as well.

3. Winter Park Urology Settles Whistleblower/Qui Tam Lawsuit

A federal whistleblower/qui tam lawsuit against a local physician group was settled in September 2013. The lawsuit — [United States v. Winter Park Urology Associates, P.A.](#) — alleged that both Winter Park Urology Associates, P.A., and Radiation Oncology Consultants, P.A., fraudulently billed the government for radiation therapy services from 2007 until 2010. According to the complaint, the physician group was accused of using radiation therapy to treat cancer patients without the supervision of a physician. It was also alleged that the clinics received \$20 million in reimbursements. The former director of Winter Park Urology was identified as the whistleblower.

From our review of qui tam/whistleblower cases, it appears most of these are filed by physicians, nurses or hospital staff employees who have knowledge of false billing or inappropriate coding

taking place. Normally the government will want to see actual documentation of the claims submitted by the hospital or other institution. Usually physicians, nurses or staff employees have access to such documentation.

4. Mid-Level Providers Bring Different Risks to Practice

With federal incentives aimed at more collaborative care and declining physician reimbursements, there's a growing demand for physician extenders, such as physician assistants (PAs) and nurse practitioners (NPs). This expanded role of mid-level providers also increases the risk of liability placed on their supervising physicians.

There are a number of possible legal claims that can be brought against physicians supervising mid-level providers. These may include: vicarious liability, agency and negligently failing to supervise. Vicarious liability, sometimes called "respondeat superior," is a legal theory that automatically assigns liability to an employer or supervisor of a negligent party. Agency is a legal theory that holds a person responsible for acts committed by his or her "agent" or one to whom he or she (often referred to as the "principal") has given the authority to act. A cause of action based on the negligent failure to supervise speaks for itself. It is a person's failure to properly supervise those over whom he or she has an authoritative relationship.

When a physician is employing a mid-level provider, there are rules about their duties and required supervision laid out by state boards and other regulatory authorities. Knowing your state's supervision requirements is key to reducing legal dangers and defending potential claims.

As a supervising physician, it is also important to be sure you maintain rapport and close frequent communications with your mid-level providers. Keep the channels of communication open at all times.

5. CMS Issues Conditions of Participation (COPs) for Community Mental Health Centers

On October 28, 2013, the CMS announced a Final Rule establishing conditions of participation (COPs) for Medicare-certified community mental health centers (CMHCs). The Final Rule is CMS 3202-F.

COPs are the health and safety regulations Medicare providers must meet in order to participate in the Medicare program and receive reimbursements. CMS has finalized six (6) new COPs for CMHCs:

1. **Personnel qualifications** establish staff qualifications for the CMHC and require that staff providing direct patient care services to be appropriately licensed and certified and to act only within the scope of the applicable license or certification;
2. **Client rights** emphasize a CMHC's responsibility to respect and promote the rights of each CMHC client by providing verbal and written notice of client rights;

3. **Admission, initial evaluation, comprehensive assessment, and discharge or transfer of the client** reflects the critical nature of a comprehensive assessment in determining appropriate treatments and accomplishing desired health outcomes;
4. **Treatment team, active treatment plan, and coordination of services** incorporate a person-centered interdisciplinary team approach, in consultation with the client's primary health care provider;
5. **Quality assessment and performance improvement** requires each CMHC to build and monitor its own data-driven quality assessment and performance improvement system to monitor and improve client care; and
6. **Organization, governance, administration of services, and partial hospitalization services** charge each CMHC with the responsibility for creating and implementing a governance structure that focuses on and enhances its coordination of services to better serve its clients.

These new regulations take effect on October 29, 2014. To verify CMHCs are meeting the new requirements, CMS will survey these centers at least once every five years. Considering the scrutiny that has been applied recently to the provision of mental health services, we expect surveys to be much more frequent.