VORYS *On the Horizon in* HEALTH LAW

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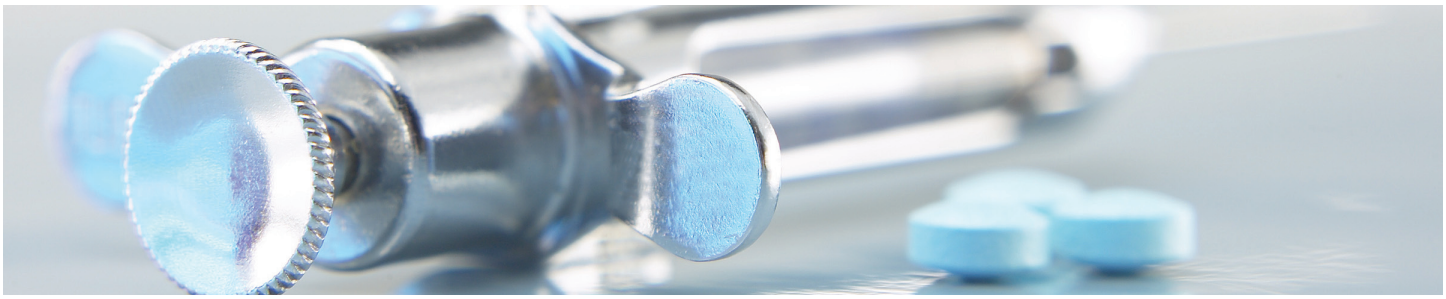

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MEDICARE AND MEDICAID

MSP Mandatory Reporting Requirements To Take Effect July 1, 2009

On July 1, 2009, health care providers that self-insure their workers' compensation plans and/or professional liability risks will become subject to a new federal mandatory reporting law. This law, codified at 42 U.S.C. § 1395y(b)(8), requires all liability insurance (including self-insurance) carriers, no-fault insurance carriers, and workers' compensation plans to report settlements, judgments, awards or other payments with/to a Medicare beneficiary to the federal Centers for Medicare and Medicaid Services ("CMS"). Penalties for non-compliance with these new reporting requirements are significant — $1,000 per day, per file for as long as the claim is not reported.

Under the new law, which was designed to maximize Medicare Secondary Payer ("MSP") recoveries, insurers must, "determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the [Medicare] program." See 42 U.S.C. § 1395y(b)(8)(A). If the insurer determines that the claimant is a Medicare beneficiary, then certain information must be reported to CMS including, but not limited to the claimant's name, date of birth, address, social security number or health identification number, insurance information including type of insurance and policy and claim numbers, policy holder information, date of injury, and claim resolution information. The required information must be submitted "after the claim is resolved through settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability)." 42 U.S.C. § 1395y(b)(8)(R) (emphasis added).

Before the new Mandatory Insurer Reporting law takes effect, all entities required to comply with the new law must register with the CMS Coordination of Benefits Contractor ("COBC"). This electronic registration must be completed by the insurer itself (not a designated agent)

between the dates of May 1, 2009 and June 30, 2009. The secure registration website is still being developed by CMS, but will be posted at www.cms.hhs.gov/MandatoryInsRep, sometime before May 1, 2009. CMS has also indicated that it intends to provide online training courses on the registration process. Interested parties may enroll in this training in advance by calling (646) 458-6740.

Once the registration process is completed, there will be a testing period, following which insurers will be expected to submit their first reports to CMS between January 1, 2010 and March 31, 2010. These initial file submissions must generally report on all claims where the injured party is/was a Medicare beneficiary that are resolved (or partially resolved) through a settlement or other payment after June 30, 2009. Insurers must also report on claims where there is responsibility for ongoing payments for medical services as of July 1, 2009, even in cases where the initial resolution occurred prior to July 1, 2009. CMS is permitting insurers to delay reporting on claims settled prior to July 1, 2009 until July, 2010 to allow the necessary information to be gathered.

FRAUD AND ABUSE

OIG Pulls Back On Scope Of Provider Self Disclosure Protocol, Sets Minimum Value On Disclosures

In an Open Letter to Health Care Providers, dated March 24, 2009, the Office of Inspector General, Department of Health and Human Services, has notified providers that it will no longer entertain disclosures of violations of the physician self referral law within the scope of the Provider Self Disclosure Protocol ("SDP"), unless they involve risk of liability under the federal anti-kickback statute. The letter goes on to state that there will now be a $50,000 minimum settlement amount on those disclosures that the OIG will continue to accept for treatment within the SDP. This position pulls back on the 2006 self-disclosure initiative articulated by the OIG in an Open Letter to Health Care Providers, dated April 24, 2006, that was aimed at specifically including within the scope of the SDP physician self referral law violations between physicians and hospitals.

The SDP, first promulgated by the OIG in October 1998, was designed to provide a formal avenue for providers to voluntarily disclose health care compliance issues that may amount to violations of federal civil, criminal and administrative laws.[1] It provides the prospect of more favorable dispositions for such matters with respect to on-going compliance demands and the civil monetary penalties and program exclusion risks that attend such misconduct. The SDP is not intended to address billing errors and overbilling situations. Compliance with the SDP generally results in settlements with providers "at the lower end of the damages continuum."

Since its promulgation, the SDP has undergone a number of informal refinements by the OIG in the form of Open Letters. This latest refinement is aimed at refocusing the OIG's resources on illegal kickback arrangements, which have long been a high priority for the OIG, and is characterized as a measure to better utilize those resources.

The federal anti-kickback statute, 42 USC § 1320 a-7(b), is a criminal statute which, in addition to severe criminal penalties, carries the risks of severe civil monetary penalties ($50,000 for each kickback and 3 times the total remuneration) and program exclusion. It proscribes the offering, receiving, soliciting or accepting any remuneration (including any kickback, bribe or rebate) directly or indirectly in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made by a federal health care program, or the purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made by a federal health care program. Conduct subject to this statute has received consistent and intensive attention by the OIG and the Department of Justice.

The federal physician self-referral statute, 42 USC § 1395nn, commonly known as the Stark law, prohibits physicians making referrals for Medicare designated health services to entities with which they or immediate family member have a financial relationship unless the relationship fits within a statutory or regulatory exception. This statute is a civil statute which imposes strict liability and carries with it risks of severe civil monetary penalties ($15,000 per service billed in violation and 3 times the amount of the subject claims) and program exclusion.

The March 24, 2009, Open Letter claims to signal no change in the government's approach to the Stark law. The OIG will continue to focus its energies on dealing with voluntary disclosures of violations of the federal anti-kickback statute under the SDP, provided the disclosing parties are prepared to enter into a settlement of as least $50,000.

TAXATION

Stipends Paid To Residents Of Detroit Medical Center Constitute Wages For Income And Social Security Tax Purposes

In *United States of America v. Detroit Medical Center*, 557 F.3d 412 (Sixth Cir. 2009), the Sixth Circuit rejected arguments by the Center that stipends received by residents qualified as "scholarships" or "fellowships" and were,

[1] See 63 Fed. Reg. 58,399 (October 30, 1998); http://oig.hhs.gov/fraud/selfdisclosure.asp.

therefore, excludable from "gross income" for Federal income tax purposes. Also rejected was the Center's contention that the stipends were exempt from FICA taxes because the residents were "students."

The Center sponsors a graduate medical training and education program jointly with Wayne State University. The program is designed to satisfy the two-year post-graduate medical training requirement imposed in Michigan as a condition for taking the state medical board examination.

Each resident signs an agreement specifying the duties and responsibilities of the resident, which includes a requirement that the resident provide patient care commensurate with his or her level of advancement and general competence. The agreement also provides for the payment of a stipend of slightly more than $40,000.00 per annum. Patients are not charged for any services they receive from a resident.

In concluding that the stipends were includable in "gross income", the Court found that the payments did not meet the definition of a "scholarship" or "fellowship" for at least two reasons. First, in order to qualify as a "scholarship" or "fellowship," the funds must be used to pay for qualified tuition and related expenses at an educational organization which normally maintains a regular faculty and curriculum with a regularly enrolled body of pupils or students in attendance. Here, these stipends were not used to pay for tuition or other related educational expenses. Second, the payments must constitute a "no strings" educational grant with no requirement of any substantial *quid pro quo* from the recipient. In this case, it was clear that these payments were not "no strings" educational grants. The *quid pro quo* was patient care performed by the resident.

With respect to the question of whether the stipends were "wages" for FICA purposes, the Court found that payments for services performed in the employ of a university, if the services are performed by a student who is enrolled and regularly attending classes at the university, are exempt from FICA taxes. However, the Court also found that the question of whether or not the residents were "students" was not properly before it and accordingly remanded the case to the District Court for further proceedings as to whether the residents were "students." In order to develop a record to aid the District Court in deciding this issue, the Sixth Circuit suggested that the parties address how many hours per week a resident spends at the hospital; how many hours per week a resident spends in the classroom; what other responsibilities a typical resident has under the program; whether the resident spends most or all of his or her time in providing patient care, or does it include other activities; the role played by the professors at Wayne State University in supervising residents; and who employed the residents.

PROFESSIONAL LICENSURE

State Medical Board Of Ohio Requires Strict Compliance In Licensing Applications

The Tenth District Ohio Court of Appeals recently upheld a decision to permanently deny an application for licensure for failure to fully and truthfully complete the licensure application. In *Bhama v. State Medical Board of Ohio*[2], Dr. Savitri Bhama applied for a license to practice medicine in Ohio. The State Medical Board of Ohio ("Board") required Dr. Bhama to submit an application, which asked whether she had ever resigned, been terminated, or asked to resign from a position she held. Dr. Bhama answered "no" to this question, even though she had in fact resigned and been terminated from various positions. Furthermore, Dr. Bhama failed to account for five years in which she did not practice medicine. Based on her failure to fully and truthfully answer this question, the Board denied her application for a certificate to practice medicine and surgery in Ohio. Dr. Bhama requested an administrative hearing. After review of the matter, the hearing examiner recommended permanent denial of Dr. Bhama's application for licensure. In so ruling, the hearing examiner concluded that Dr. Bhama's answers constituted a "false, fraudulent, deceptive or misleading statement" and demonstrated a "failure to furnish satisfactory proof of good moral character" in violation of Ohio law.

On appeal, Dr. Bhama sought to explain her reasoning behind her application answers. Regarding the resignations, Dr. Bhama stated that she thought it was implied that one would resign before moving on to another job. Furthermore, Dr. Bhama stated that she figured the Board would contact each employer to ascertain her exact employment history. Overall, she believed the Board was only interested in resignations or terminations involving issues of patient care. Resolution of this matter turned on whether Dr. Bhama intentionally misled the Board by failing to disclose her resignations and terminations. In considering Dr. Bhama's explanations, the Court recognized that both the hearing examiner and the Board found those explanations to be implausible. The application question was direct and straightforward and not subject to interpretation. Furthermore, Dr. Bhama failed to disclose the fact that she did not practice medicine for five years. These facts adequately supported the conclusion that Dr. Bhama intended to mislead the Board and demonstrated a failure to furnish satisfactory proof of good moral character.

[2] No. 08AP-488, 2009 WL 444350 (Ohio App. 10th Dist. Feb. 24, 2009)

Physician Agreement To Accept Inactive Status Of Medical License In Foreign Jurisdiction Provides Sufficient Grounds For Ohio Medical Board Disciplinary Action

The Court of Appeals in Franklin County, Ohio, recently upheld a State Medical Board of Ohio decision that found that a physician's voluntary surrender of his medical license in a foreign jurisdiction, without admission of wrongdoing in order to resolve accusations of substandard care, is a limitation on the physician's ability to practice medicine such that the Ohio Board may itself impose disciplinary action. In *Robert C. Gross, D.O. v. Ohio State Medical Board*[3], the Court rejected the notion that disciplinary action by the Ohio Board could not be imposed based solely upon the action of another state's medical board in placing the physician's license in permanent inactive status, and affirmed the proposition that disciplinary action may rest entirely on the foreign medical board's findings.

Dr. Robert Gross entered into a stipulation with the Colorado State Board of Medical Examiners whereby his license to practice medicine was placed on permanent inactive status, an action which resolved, without an admission of wrongdoing, that Board's disciplinary proceedings. The Colorado Board's initiation of disciplinary action against Dr. Gross was based on its finding that in seven cases he failed to meet "accepted standards of medical practice." The Ohio Medical Board then initiated disciplinary proceedings based upon the action of the Colorado Board. Following a hearing, at which no evidence of substandard care was presented, the Ohio Board temporarily limited and restricted Dr. Gross' medical license and imposed a term of probation.

In his appeal, Dr. Gross argued that the Ohio Medical Board deprived him of due process by relying on the factual assertions of substandard care that prompted the Colorado Board's action. The Court disagreed, finding that the Ohio Board's written notice of the basis for its action, combined with the opportunity for hearing and an appearance before the Ohio Board, satisfied his procedural due process rights.

Dr. Gross also argued that the Colorado action did not constitute a "limitation" on his ability to practice sufficient to support the stated grounds for the Ohio Board's disciplinary action. In his view, the Colorado Board's action was not a limitation on his ability to practice but an administrative inactivation of his license. The Ohio Board initiated its proceedings under Revised Code Section 4731.22(B)(22), which authorizes it to take disciplinary action if an agency responsible for regulating the practice of medicine or osteopathic medicine in another jurisdiction takes action that constitutes a "limitation" of an individual's license to practice. The Court analyzed the term "limitation" as used in the statute and concluded that it was to be given its everyday, common meaning. By doing so, the Court found the Colorado Board's action resulted in an "enforceable restriction" on Dr. Gross' ability to practice medicine in that jurisdiction that provided a cognizable limitation upon which the Ohio Board could act.

In addition, Dr. Gross argued that the common pleas court that initially heard his appeal from the Medical Board's order, erred in refusing to modify the terms of the Ohio Board's Order. The appellate court found that the lower court lacked the authority to modify the Medical Board's penalty, as it was lawfully imposed. In doing so, the court reiterated the position it had taken in previous Medical Board cases that deference is due the decisions of the Medical Board when they are supported by reliable, probative and substantial evidence, and in accordance with law. In judging the Medical Board's decision to be so grounded, it overruled that claim of error.

[3] Franklin County, No. 08AP-437, December 23, 2008.