

Healthcare UPDATE

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Who's Watching You Now

By Kimberly Greaves

For more than a decade the National Practitioner Data Bank ("NPDB") has been used to monitor malpractice and adverse peer review actions against physicians. In 1996, the Health Insurance Portability and Accountability Act ("HIPAA") added a second tool via the Health Care Integrity and Protection Data Bank ("HIPDB" and fondly referred to as "HipeeDippee"), which went into effect in November 1999. HIPDB is a national data bank established to receive and disclose certain fraud and abuse actions against health care providers, suppliers or practitioners. The two data banks are intended to be complementary and not overlapping. Both are managed for the DHHS Inspector General's office by the Health Resources and Services Administration and the two have been integrated into a single NPDB-HIPDB Integrated Querying and Reporting Service and accessible via the World Wide Web at www.npdb-hipdb.com.

Although measures have been taken by DHHS to safeguard the integrity and confidentiality of information contained in these data banks, both systems have their shortcomings. Providers must be aware of what specific actions are reportable to the NPDB and the HIPDB, who may have access to such information, the purposes for which such information can be used, and what rights providers have to access and correct information submitted to the data banks.

NPBD

What is it?

The NPDB was created by the Health Care Quality Improvement Act ("HCQIA") of 1986. Through HCQIA, legislators sought to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance. HCQIA created a requirement for reporting certain adverse actions against physicians while at the same time encouraged participation in formal peer review processes and subsequent reporting by granting qualified immunity to certain professional review bodies. The HCQIA establishes a database and authorizes the collection of information about individual practitioners in the following categories: (i) adverse actions on clinical privileges taken by hospital and other qualifying healthcare entities; (ii) adverse actions on membership in certain qualifying professional societies; (iii) reports of medical malpractice payments and (iv) reports of negative actions taken by state licensing authority.

Supreme Court Decision Precludes Claims Against HMOs Based on Fiduciary Status

By Tara L. Adyanthaya

In an important decision for all physicians and health maintenance organizations, the U.S. Supreme Court (the "Court") recently held that a patient generally cannot sue an HMO under ERISA for coverage/treatment decisions of an HMO's physicians. That same decision, however, opens the door for prosecution of such a suit in state court under a common-law malpractice theory.

In Pegram v. Herdrich, 530 U.S. 1, 120 S.Ct. 2143 (2000), the U.S. Supreme Court (the "Court") determined whether treatment decisions made by a Health Maintenance Organization ("HMO"), acting through its physician employees, are fiduciary acts within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Court held that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA and therefore held that Herdrich's ERISA claim failed to state an ERISA claim.

The facts of the case are as follows. Cynthia Herdrich was covered by an HMO, Carle Clinic Association ("Carle") and saw Defendant Dr. Pegram, a physician-owner of co-defendant Carle, complaining of pain in her abdomen. Six days later,

CON Update

By Daniel J. Mohan

On March 9, 2000, the Division of Health Planning of the Georgia Department of Community Health adopted a new rule (the "Rule") governing the issuance of Letters of Non-Reviewability ("LNRs") for physician-owned, single specialty, office-based ambulatory surgery facilities ("ASF"). The new Rule was subsequently amended by a proposed revision to the Rule which became effective as of August 10, 2000. This new Rule may be found at Rule 272-2-.07(5), in the "Exclusions" section of the Division's Administrative Rules. It establishes 18 criteria that an applicant must meet in order to obtain a LNR for a physician-owned, single-specialty, office-based ASF. Among the more significant changes effected by this new Rule are the following:

1. The applicant must provide a detailed description of the "proximity" of the group's clinical offices to the proposed ASF. The Division will issue a LNR only if the proposed ASF is in "reasonable proximity" to the group's clinical offices, which will be determined by the Division on a case-by-case basis.

2. The applicant must submit "detailed information" on all costs associated with the construction, development and establishment of the ASF. This information must include all construction costs for new construction (even if the space will be leased), the cost of all purchased equipment, the present value of any equipment leases, the amount of all architectural, engineering, legal and administrative fees, and all financing and underwriting costs.

3. The Division will not issue a LNR to a sole practitioner or a single-specialty group practice if that individual or group bills professional fees through a larger multi-specialty group practice of which the individual or group will remain a part. The amendment to the Rule made it clear, however, that this provision would not preclude the issuance of a LNR to a physician(s) which utilizes a larger group practice for the "sole purpose" of billing services under the provider number of the sole physician or single group practice.

4. The Division will not issue a LNR to a physician that is a part of more than one group practice.

5. The Division will not issue a LNR to a group practice if any members of the group are also members of a multi-specialty clinical practice. Under the amendment, however, the term "multi-specialty clinical practice" does not include a volume purchasing association or a managed care network that has as its purpose managed care contracting in which the physician or group practice participates.

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Fraud and Abuse Update

By Bradley H. Pruitt

Government Issues Compliance Program Guidance for Physicians

On June 7, 2000, the OIG issued a draft of compliance guidelines (the "Guidelines") for solo and small physician groups. These Guidelines follow compliance guidelines previously issued by OIG pertaining to billing companies, hospitals, skilled nursing facilities, and other providers.

In the preamble to the Guidelines, the OIG discussed the distinction between "fraudulent" and "erroneous" claims. OIG stated that it believes that the majority of physicians work ethically and render high quality medical care and submit proper claims. OIG promises that physicians will not be subject to civil or criminal penalties for innocent errors, or even negligence. OIG emphasizes that all medical providers have a duty to ensure that the claims submitted to federal healthcare programs are reasonably true and accurate. It also recognizes, however, that the best physicians and their staffs make billing mistakes and that, upon discovery of these mistakes, the physician would be asked only to return the funds erroneously claimed, without penalties.

Under the Guidelines, the following activities are identified as high-risk areas for physicians:

1. unbundling of tests;
2. kickbacks for patient referrals;
3. routine waiver of co-payments and deductibles, regardless of need;
4. billing for "no shows";
5. upcoding;
6. double-billing such as billing both Medicare and beneficiary/insurer;
7. billing for physician services rendered by non-physicians;
8. failure to adequately document medical necessity;
9. misrepresenting diagnoses to justify services;
10. completing certificates of medical necessity for patients not personally or professionally known by the physician;
11. billing federal health care programs for investigative research, medications and procedures without proper authorization; and
12. billing for non-covered services as if they were covered.

Consistent with compliance guidance that OIG has previously given with respect to other providers, OIG recommends that physician groups develop and implement a compliance plan to minimize the risk of violating federal law and to immediately identify and deal with violations that may occur. The Guidelines specify seven basic elements to a proper physician practice group compliance program. These seven elements are consistent with elements identified by OIG in compliance outlines applicable to other providers, and are as follows: (1) establish-

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Fraud and Abuse Update

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ment of a code of conduct; (2) appointment of a compliance officer; (3) training and education for all employees; (4) monitoring and auditing all aspects of the practice; (5) communication of employee's responsibilities under the law and the compliance plan; (6) enforcement; and (7) immediate and formal response to violations. OIG acknowledges, however, that many solo and small physician group practices have limited resources with which to implement a full-fledged compliance program. Thus, under these Guidelines, a physician practice need not follow all elements if some are inapplicable.

Throughout the guidance, the OIG suggests how practices can foster a culture that embraces compliance consistent with the size and resources available to the physician practice. For example, the OIG suggested that instead of operating a confidential hot line to receive complaints, a small practice might implement a clear "open door" policy for employees to identify concerns about compliance issues. Dedicating an office bulletin board to compliance information might also be a way to make sure everyone in the practice has access to up-to-date compliance information. In situations where a practice cannot afford to designate an employee to oversee compliance activities, the guidance suggests that those responsibilities be divided among practice staff who would then serve as "compliance contacts." Another possibility is outsourcing all or part of the compliance functions to a consultant, billing company or other entity.

The Guidelines also provide direction to larger practices in developing compliance programs by recommending that these practices use both the physician guidance and other previously issued guidance, such as the Third-Party Medical Billing Company Compliance Program Guidance or the Clinical Laboratory Compliance Program Guidance, to create a compliance program that meets all of the needs of larger practices. The guidance also includes several appendices outlining risk areas physicians should be familiar with, basic information about criminal, civil and administrative statutes related to the federal health care programs, and information about the OIG's provider self-disclosure protocol, how to request an advisory opinion and Internet resources that may be useful to physician practices.

The Guidelines are still open for public comment, and many comments have been submitted to OIG by interested parties. OIG has established no timetable for considering the comments and the issuance of final Guidelines.

OIG Issues Fraud Alert on Rental of Physician Office Space

On February 23, 2000, the OIG issued a **Special Fraud Alert** addressing questionable space rental arrangements in physicians' offices. The Fraud Alert focused on the rental of space in physicians' offices by persons or entities providing health care items, services or supplies to patients that are referred either directly or indirectly by their physician landlords. Concerned that such arrangements may be disguised kickbacks to the physician-landlords to induce referrals to the health care item supplier, the OIG stated it will look at such arrangements and consider with particularity the following factors: (1) the appropriateness of the rental agreements; (2) the rental amounts; and (3) time and space considerations. The Fraud Alert set forth a formula to determine the appropriate amount of rent for exclusive space by a supplier. It further emphasized the need for these arrangements to meet the space rental safe harbor, the equipment rental safe harbor and the personal services and management contracts safe harbors under the anti-kickback law.

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6. The Division will not issue a LNR in any case where the applicant proposes to share operating rooms or common space in the proposed ASF with any other party.

7. The applicant must certify that it will not incur additional capital expenditures, or expenditures for the addition or replacement of any equipment, for *three* years after the issuance of the LNR which expenditures (when coupled with any prior similar expenditures), would cause the aggregate expenditures to exceed the applicable capital or equipment expenditure threshold.

8. The LNR is not transferable to the "purchaser" of the group practice.

In addition to these new restrictions, the Division reaffirmed its existing policy of permitting up to 15% non-physician ownership in the ASF. In addition, in a departure from its previous policy, the Division expressly recognized that employed physicians would be permitted to utilize the ASF, so long as these physicians were not employees of any other group practice.

This new Rule has made it significantly more difficult for physicians to obtain LNRs for a physician-owned, single-specialty surgery center. In adopting this Rule, the Division has served notice that it will no longer consider, or approve, more flexible proposed arrangements that it had in the past found acceptable. The new criteria related to sharing of space and the three (3) year expenditure review cycle, in particular, are significant departures from the Division's past practices in this area.

The Division's adoption and enforcement of this Rule also serves to emphasize the increasing competitiveness of the healthcare marketplace. Obviously, to the extent that the adoption of the Rule results in the issuance of fewer LNRs to physician applicants, hospitals and existing free-standing surgery centers will benefit. This fact is reinforced by the increased incidences of third-party challenges to LNRs. For example, the Georgia Alliance of Community Hospitals, a statewide lobbying organization for non-profit hospitals, has been particularly aggressive in challenging LNR requests, even going so far as to file a lawsuit against the Division in connection with the Division's approval and issuance of a LNR for an ASF in Savannah. As reimbursement for hospitals and physicians continue to be reduced, the tensions will continue to mount.

Supreme Court Decision

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Dr. Pegram found an inflamed mass in Herdrich's abdomen. Despite there noticeable inflammation, Dr. Pegram did not order an ultrasound at a local hospital, but decided that Herdrich should wait eight more days for an ultrasound to be performed at a Carle facility more than 50 miles away. Before the eight day period expired, Herdrich's appendix ruptured, causing peritonitis. 530 U.S. at 1-2.

In the lower court, Herdrich prevailed on her state law malpractice claims, receiving \$35,000 in compensation for her injury. She did not, however, prevail on her claim that the Carle HMO's system of rewarding its physician-owners for limiting medical care entailed an inherent or anticipatory breach of an ERISA fiduciary duty. Herdrich contended that these terms created an incentive to make decisions in the physician's self-interest, rather than in the interest of plan participants. Herdrich sought relief under 29 U.S.C. § 1109(a), which provides that

[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from such breach, and to restore to such plan any profits of such fiduciary which had been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

The lower court granted defendant's motion for dismissal for failure to state a claim, finding that Carle was not involved in the events as an ERISA fiduciary. 530 U.S. at 4. The 7th Circuit Court of Appeals reversed. That court held that Carle was acting as a fiduciary when its physicians made the challenged decisions and that Herdrich's allegations were sufficient to state a claim:

Our decision does not stand for the proposition that the existence of incentives automatically gives rise to breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists. (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses). 154 F.3d at 367.

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Who's Watching You Now

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What Must Be Reported to the NPDB and By Whom?

Medical malpractice insurers and other entities making payments in satisfaction of malpractice claims must report to the NPDB any payments made in satisfaction of a malpractice claim or judgment, regardless of the amount of the payment and regardless of whether the case is settled prior to filing suit. Reports of payments are required even if the settlement agreement is sealed as confidential. Interestingly, entities must report all payments made on behalf of individual practitioners, but they are not required to report payments made solely for the benefit of a clinic, group practice or hospital.

Professional review actions that *adversely affect* a practitioner's clinical privileges must also be reported. However, adverse review actions are reportable only if they are related to professional competence or professional care. Denials or limitations of clinical privileges based on non-clinical or administrative factors are not reportable events under the NPDB. Practitioners should note that reporting is also required when a practitioner surrenders his clinical privileges while he is under investigation by the entity for possible improper conduct. However, an entity is only required to report adverse actions that result from "formal professional review." The problem with this requirement is that the HCQIA does not prescribe any specific procedural requirements that must be followed to show that a "formal professional review" process took place requiring reporting. Courts have given some guidance in his regard by requiring the entity conducting the professional review to adhere to the entity's bylaws in conducting a professional review action, but the extent of the procedural protections afforded to a practitioner in challenging adverse privileging actions is limited in scope. Consequently, absent basic unfairness, courts are unlikely to direct removal of an adverse report to the NPDB and courts have held that practitioners have no constitutional right to remove a NPDB report.

What if Incorrect Information is Submitted?

Needless to say, a report, particularly an incorrect one, can be devastating to a practitioner's career, especially in light of the fact that reports are never expunged by the NPDB. Therefore, it is imperative that entities required to make reports do so with the utmost care, making sure that the information they submit is accurate and that they carefully identify the practitioner. The reporting entities should also update the NPDB through the submission of an amended report, referred to as a Revision of Action report, when there is a change or modification of a previously-reported action.

Although NPDB reporting entities have an obligation to submit correct and updated information, it is in the practitioner's best interest to self-monitor what information has been reported and make sure that Revision of Action reports are filed when appropriate. Upon the entry of a report into the NPDB, a copy of the report is sent by the NPDB to the subject practitioner. The practitioner is expected to review the information and file a request for correction with the reporting

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Court of Appeals Rules on Blue Cross Changes to Usual and Customary Reimbursement Formula

By Robert Threlkeld

In a case that is of interest to providers and third party payors alike, the Court of Appeals recently issued a ruling in Medical Association of Georgia v. Blue Cross & Blue Shield of Georgia, Inc. (June 19, 2000), that impacts the ability of third party payors to alter reimbursement rates under provider contracts. The Medical Association of Georgia had filed suit on behalf of various physicians who had entered into contracts with Blue Cross to provide medical services to Blue Cross members in exchange for reimbursement by Blue Cross of the usual, customary and reasonable fees. The provider contracts stipulated that Blue Cross had the authority to determine usual, customary and reasonable fees, and when a provider's charges exceed the usual, customary and reasonable allowance, the doctors would abide by the rules and regulations of Blue Cross.

Under the Blue Cross rules and regulations, the usual, customary and reasonable fee program could be changed when deemed advisable by Blue Cross to reflect changes in conditions. According to the opinion, the Blue Cross rules further provided: "Reimbursement programs are subject to change, both generally, as to methodology, and specifically for certain customers, geographic areas, services or supplies. Participating physicians will be notified of changes in reimbursement programs at least 30 days prior to the effective date of any change."

In 1997, as we previously reported, Blue Cross notified physicians of a change to its usual, customary and reasonable fee reimbursement program. At that time, Blue Cross changed the meaning of "usual, customary and reasonable" from the fee that doctors usually charge in a given area, to the fee that doctors in a given area usually receive for a particular services.

On behalf of the physicians, MAG alleged that Blue Cross had breached an implied covenant of good faith and fair dealing by changing the definition of usual, customary and reasonable. The trial court rejected that claim, and the Court of Appeals affirmed. The Court of Appeal noted there can be no breach of a duty of good faith when a party to a contract does what the contract allows. Because the rules and regulations incorporated into the provider agreements permitted the change, there was no breach of a covenant of good faith and fair dealing.

MAG also alleged that the provider contracts were unenforceable because the payment terms under the amended rules were unascertainable. MAG asserted that the physicians could not determine whether they were being properly reimbursed because they did not have access to the fee schedule or the precise methodology used to determine usual, customary and reasonable fees. On this point, the Court of Appeals agreed, holding that the refusal to provide physicians with a fee schedule and the precise methodology was improper. This is because a promise of future compensation must be based on an exact amount or formula ascertainable from the contract. However, the Court held that this did not render the contracts invalid. Rather, it sent the case back to the trial court with instructions that Blue Cross must provide the fee schedule and the precise methodology used to determine payments.

The case has important implications for physicians and other providers. First, any provider that enters into a provider contract should review it carefully as to all of its provisions, and specifically with respect to the reimbursement formula. If the contract itself, or any payor regulations that it incorporates, entitles the payor to change the formula on a going forward basis, then the provider should assume this is permissible. At the same time, to the extent a contract does not permit a calculation of the fee schedule or reimbursement formula, the physician should request that be provided prior to entering into the contract, because the Blue Cross opinion suggests that each provider is entitled to it.

Meet Sidney N. Summers

Sidney N. Summers is our newest healthcare associate. Summers specializes in representing physicians and physician groups. Her expertise includes:

- Federal and state regulatory healthcare matters, including the federal Antikickback Statute, Stark II, the False Claims Act, internet privacy and security issues under the Health Insurance Portability & Accountability Act, state self-referral laws, fee-splitting, and corporate practice of medicine;
- Medicare and Medicaid reimbursement issues, investigations, audits and appeals;
- Negotiating business and contractual relationships with other physicians, hospitals, and third parties;
- Structuring business relationships from a corporate and regulatory perspective;
- Providing representation to physicians before the Composite State Board of Medical Examiners;
- Representing physicians and Medical Staffs in credentialing matters before hospitals and insurance companies;
- Drafting Medical Staff Bylaws and other matters;
- Dispute resolution and litigation matters.

During law school, Summers clerked with the University of Alabama at Birmingham Medical Center and the Office of General Counsel for the American Medical Association. Summers is a frequent speaker on healthcare topics for numerous sponsors, including the Medical Association of Georgia, the American Medical Association, MAG Mutual Insurance Company, and the Georgia Society of Ophthalmology.

Most recently, Summers spoke at the Fourth Annual Phystar Medical Management Conference on HIPAA: Privacy and Security Compliance.

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Supreme Court Decision

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The U.S. Supreme Court then reversed. Writing for the Court, Justice Souter noted that ERISA provides that fiduciaries shall discharge their duties with respect to a plan “solely in the interest of the participants and beneficiaries”, in other words, “for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) differing reasonable expenses of administering the plan.” The Court found these responsibilities were similar to those found in the common law trusts. Unlike ordinary fiduciaries, however, an ERISA fiduciary can have financial interests adverse to beneficiaries. For example, employers can be ERISA fiduciaries yet still take actions to the disadvantage of employee beneficiaries, such as firing a beneficiary for reasons unrelated to the ERISA plan. Thus, in every case charging breach of ERISA fiduciary duty, the threshold question is not whether the actions of a person employed to provide services under a plan adversely affects a plan beneficiary, but, rather, whether that person is acting as a fiduciary when taking the action subject to complaint.

In *Pegram*, the Court determined that the acts alleged to be fiduciary in nature were in fact mixed eligibility and treatment decisions made by physicians. In other words, a physician’s conclusion about when to use a diagnostic test, seek a consultation and make a referral to physicians and facilities, other than Carle’s, involve questions about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. The Court determined that Congress did not intend for Carle, or any other HMO, to be treated as a fiduciary to the extent that it made mixed treatment and eligibility decisions acting through its physicians. It noted that at common law, fiduciary duties characteristically attached to decisions to about managing assets and distributing property to beneficiaries. The Court found that mixed eligibility decisions by an HMO acting through its physicians have only a limited resemblance to the usual business of traditional trustees.

Policy reasons also influenced the Court’s decision. The Court determined that the relief sought by Herdrich, the return of profit from Carle HMOs’ owners, could result in nothing less than the elimination of the for-profit HMO as an entity, and potentially could portend the end of non-profit HMOs as well. More importantly, Justice Souter wrote, the judiciary should not “precipitate the upheaval that would follow a refusal to dismiss Herdrich’s ERISA claim.” Justice Souter noted that for over 27 years Congress promoted the formation of HMO practices. 530 U.S. at 21 (citing the Health Maintenance Organization

Act of 1973, 87 Stat. 914, 42 U.S.C. § 300(e), *et. seq.*) If Congress wished to restrict its approval of HMO practice to certain preferred forms, the Court found that it could chose to do so but declined to act contrary to the congressional policy of promoting the existence of HMOs.

Justice Souter also was reluctant to convert the fiduciary standard under ERISA to a common-law, duty-of-care standard under state malpractice law. The Court noted that in every case an HMO would defend itself by arguing that a physician acted not out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. Thus, the Court determined that for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians. Noting too that physicians would also be subject to suit in federal court applying an ERISA standard of reasonable medical skill, the Court determined that this would raise a puzzling issue of preemption. On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state law malpractice claim. The Court determined that the only benefits to be gained by opening the federal court house doors for fiduciary malpractice claims, would be random fortuities such as more favorable scheduling or the ancillary opportunity to seek attorneys’ fees.

While foreclosing an ERISA action based upon a treatment decision, the Court may have left the door open for one potential claim under ERISA. In footnote 8, Justice Souter observed that Herdrich could have argued that Carle had a fiduciary duty to disclose physician incentives to limit care. A breach of that duty might still give rise to an ERISA claim. More importantly, the decision invites malpractice actions in state court against HMOs based on eligibility/medical decisions. By definition, such actions will not be pre-empted. Justice Souter’s decision in *Pegram* will be extremely important for the future course of malpractice actions involving members of HMOs. Such malpractice claims cannot be heard in federal court under ERISA. At the same time, many of those claims will now be brought under common law duty of care theories, not only against a physician-provider but against an HMO itself.

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information and file a request for correction with the reporting entity, not the NPDB, if the information is incorrect. If the reporting entity does not cooperate, the practitioner may file a dispute with the DHHS Secretary.

The DHHS Secretary will review the accuracy of the information contained in a report, but will not review the underlying appropriateness of any medical malpractice claim or professional review action. Note that appeals to the DHHS Secretary based on arguments other than the substantive merits of the underlying action are likely to be more successful. For instance, the Secretary may direct removal reports from the NPDB if they involve non-reportable events such as a report of a suspension for less than thirty days. A practitioner is entitled to submit a statement to the NPDB if his appeal is denied. Consequently, all entities that subsequently query the NPDB will receive both the report and the practitioner's statement.

If the Practitioner is still dissatisfied after seeking a correction or removal from both the reporting entity and the DHHS Secretary, he may be able to seek judicial review under the federal Administrative Procedure Act. Under this Act, the plaintiff must first exhaust all available administrative remedies before seeking judicial review and then must meet the difficult burden of showing that the DHHS acted in an arbitrary or capricious manner in refusing to remove the report from the NPDB.

HIPDB

What is it?

HIPDB originated in HIPAA as a new tool in DHHS' arsenal against fraud and abuse. HIPDB, like the NPDB, is a national database; however, HIPDB was formed with the purpose of reporting and disclosing certain final adverse actions taken against healthcare providers, suppliers, and practitioners for healthcare fraud and abuse. Reporting to HIPDB was required as of November 1999 and entities required to report must provide information on all reportable final adverse actions taken since August 21, 1996, which is the enactment date of HIPAA.

What Information Must Be Reported to HIPDB?

HIPDB is required to collect information on (i) civil judgments, except malpractice judgments, against health care providers, suppliers, and practitioners in federal or state courts related to the delivery of a health care item or service; (ii) federal or state criminal convictions of health care providers, suppliers, and practitioners related to the delivery of a health care item or service; (iii) actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and practitioners; (iv) exclusion of health care providers, suppliers and practitioners from participation in any federal or state health care program and (v) any other adjudicated actions or decisions that the Secretary of the Department of Health and Human Services establishes by regulation.

Who Must Report to HIPDB?

Those required to report adverse actions to HIPDB include federal and state agencies such as the Department of Justice, Department of Health and Human Services, and any other federal or state agency that either administers or provides payment for the delivery of healthcare services, including the Department of Defense

and the Department of Veterans Affairs; state law enforcement agencies; State Medicaid Fraud Control Units and other federal and state agencies responsible for the licensing and certification of healthcare providers or suppliers. Also required to report adverse actions to HIPDB are private health plans which are defined as any group, organization or company providing health benefits whether directly or indirectly through insurance, reimbursement or otherwise. This includes, but is not limited to, insurance agents, brokers, solicitors, consultants and reinsurance intermediaries, insurance companies, self-insured employers and health purchasing groups.

Who May Access it?

Access to HIPDB information is limited to those who report actions under the statute. Providers and suppliers are granted the right to access the HIPDB regarding their own files at any time, however. The general public is not allowed access reports, although there have been recent attempts to make both HIPDB and NPDB information available to the public. The statute requires the information reported to be kept confidential and must be provided and used in a manner consistent with protecting confidentiality.

For What Purpose May The Information Be Used?

Persons or organizations receiving information must use it solely for the purpose for which it was disclosed. HIPDB information may be requested for privileging and employment, professional review, licensing, certification of registration, fraud and abuse investigation, certification to participate in a government program, and civil and administrative sanctions.

Concerns For Practitioners.

Similar concerns lurk with HIPDB as with NPDB. Reports can be corrected only by the reporting agency or entity and the processes, and their inadequacies, for challenging reports are virtually the same. As with reports to the NPDB, when reports are filed with HIPDB, the practitioner who is the subject of the report is notified by HIPDB and should carefully review the reported information and immediately send notification to the reporting agency or entity of any misstatements or incorrect information made in the reports. HIPDB reports remain in the data bank forever, unless removed by the reporting entity or required by a administrative review process or court order.

Furthermore, under both NPDB and HIPDB, there are risks of misidentification of providers and unauthorized access to the databases. DHHS has implemented various security features to protect against these concerns. For example, access to the databases is at least theoretically limited to authorized users with appropriate database identification numbers and passwords and special application software. However, software can be copied and "secured" passwords have been obtained with relative ease. Therefore, DHHS must continue to work diligently to safeguard the security of its computerized databases. In the meantime, practitioners must continue to closely monitor information that may be in the databases and take action quickly to challenge incorrect or misleading information.

Those interested in obtaining more information about NPDB or HIPDB should visit their website at www.npdb-hipdb.com.

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