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HEALTH LAW FOCUS

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Asset Protection Planning

By: Regis A. Carozza

Many individuals, particularly professionals who are concerned about the prospect of malpractice lawsuits, are seeking ways to structure their personal financial affairs to shelter their assets from the claims of potential creditors. Many have heard or read about the protections offered by foreign situs trusts. These trusts typically are established in jurisdictions such as the Cayman Islands, Cook Islands, and Bahamas, which have enacted legislation designed to protect trust assets from the claims of creditors. While properly structured and administered, foreign trusts can offer certain asset protection advantages, these arrangements also may present certain disadvantages which can render them unsuitable for many individuals who are attempting to implement asset protection planning.

Legitimate asset protection planning, however, need not be limited to the use of foreign trusts. Instead, a prudent and balanced approach often will encompass a broad array of other planning tools of varying complexity, including the use of joint property ownership arrangements, gifts to a spouse, qualified retirement plans and IRAs, life insurance, traditional irrevocable trusts, and business entities such as limited partnerships and limited liability companies. Additionally, domestic trusts may be established under the laws of states such as Alaska and Delaware, which have enacted legislation designed to favor trust settlors who seek to protect assets from creditors.

While the types of available planning devices may differ, certain principles are applicable regardless of the course ultimately chosen. First, asset protection planning should be carefully integrated with a comprehensive estate plan which is crafted to satisfy the specific needs and objectives of the individual. Second, advance planning is critical, since efforts undertaken after the occurrence of an event giving rise to a claim are far less likely to survive creditor attack than planning measures implemented prior to such an event. If you would like to know more about asset protection planning and how it may be incorporated into your estate plan, please contact Regis Carozza in our Detroit office at (313) 465-7342.

IN THIS ISSUE

A Proactive Approach to Physician's Audits

By: Linda S. Ross

Increasingly, physicians are the subjects of audits by third party payors. Typically, the physician receives notice of an impending audit and the auditor reviews a sampling of patient records. Based on the review, the auditor makes a determination as to whether claims that have been paid by the third party payor were properly coded, are supported by the required documentation or were for medically necessary services. Following the audit, the physician receives a letter documenting the audit results. Often, the letter includes a request for repayment for claims determined to have been paid in error. The amount of repayment requested can be modest or substantial. Generally, physicians have the right to challenge the results of an audit through informal and formal procedures. The process can be time-consuming and costly, but can result in changes to the audit findings and a reduction in the amount subject to repayment.

Here are some suggestions to aid physicians in avoiding and "surviving" audits:

1. Familiarize yourself and your staff with the coding, documentation and medical necessity requirements of the payor, and make sure that you and your staff comply with those requirements.

2. Institute a compliance place to minimize the likelihood of improper billing. Part of the plan should require conducting periodic self-audits of claims to identify potential risk areas. These audits can include a baseline audit, concurrent audits or retrospective audits. They should include a variety of services and should be performed with respect to each physician in the group. Any problem areas or irregularities should be identified and corrected promptly. The Office of Inspector General has published guidance for physicians in developing compliance plans. The guidance is available on the

internet at **www.os.dhhs.gov/proorg/oig/modcomp/index.htm**

3. If you are the subject of an audit, it is important to make a copy of any and all documents and records reviewed by the auditor, particularly those documents and records that were copied by or for the auditor. In doing so, you will have access to the exact documents that formed the basis for the auditor's conclusions. This access may be helpful should you choose to appeal the auditor's findings.

4. Typically, the audit results include various reports regarding the claims sample included in the audit. It is important to examine the auditor's conclusions carefully for consistency, completeness and accuracy. The process may involve comparing claims for services that were rejected with similar claims that were denied. Additionally, it may be helpful to obtain evidence of the applicable standard of care (e.g., in the applicable professional literature) to refute claims that a service that you provided was not medically necessary.

5. Consider retaining a lawyer and/or a billing consultant to assist you in the review and appeal of the findings.

Physician Groups Contracting With Third-Party Billing Services on A Percentage Basis

By: Carey Kalmowitz

The fact that a physician group contracts with a third-party billing service does not insulate the group from responsibility to the Medicare program for bills submitted in the group's name or containing the physicians' signatures even if the physicians themselves did not have actual knowledge of any billing impropriety. In particular, the attestation on the Form HCFA-1500 states that the physicians' services were billed properly. Thus, it is no defense for the group if the billing service improperly bills Medicare.

One of the more noteworthy risk areas involving billing services deals with physician practices contracting with billing services on a percentage-of-revenue basis. Although percentage-based billing arrangements are not, per se, unlawful, the Office of Inspector General has, on a number of occasions, articulated its concern that such arrangements potentially increase the risk of upcoding and other abusive billing practices. The rationale underlying such concern is that, because the fees earned by a billing company in a percentage-of-revenue arrangement are correlated with the amount billed, the billing agent has a financial incentive to maximize billings. In other words, these compensation arrangements may influence the billing agent's conduct because the agent is vested with a financial interest in how much is billed or collected.

Although there might be somewhat greater risks associated with a percentage arrangement than an arrangement in which the fee is on a fixed-amount-per-claim-basis, physicians nonetheless are not precluded from contracting with a billing service on a percentage basis. There are, however, a number of features that must be avoided in any such percentage-based payment arrangements. First, the billing service cannot directly receive the payment of Medicare funds into a bank account that it solely controls (i.e., in which it has the authority to endorse checks). Under applicable law, Medicare payments can only be made to either the beneficiary or the party that furnished the services and accepted assignment of the beneficiary's claim. A billing service does not qualify as a party that furnished the services and, accordingly, a billing service cannot directly receive payment of Medicare funds. The Medicare Carriers Manual §3060(A) provides that a payment is considered to be made directly to the billing service if the service can convert the payment to its own use and control without the payment first passing through the physician's control. As a practical matter, for example, the billing service should not bill the claims under its own name or tax identification number. Rather, the billing service should bill claims under the physician's name and tax identification number. Nor should a billing service receive the payment of Medicare funds directly into a bank account over which the billing service maintains sole control. The Medicare payments should instead be deposited into a bank account over which the provider has signature control.

Physicians: Check the Web Before You Hire

By: Julie E. Robertson

The Office of Inspector General ("OIG"), the federal agency established to identify and eliminate fraud and waste in federal healthcare programs such as Medicare, is urging physicians and their practice managers to "check the web" before they hire or contract with individuals or entities to provide services reimbursable under federal healthcare programs.

Under federal law, the OIG can impose civil monetary penalties on physicians and medical groups that employ or contract with an individual or entity that is excluded from participation in federal healthcare programs (an "Excluded Provider"). The penalties can be significant; the OIG is authorized to imposed fines of up to $10,000 for each item or service furnished by the Excluded Provider for which reimbursement from a federal healthcare program was claimed, as well as up to three times the amount claimed. In addition, the healthcare provider also can face exclusion from participation in federal healthcare programs.

The OIG has published its list of Excluded Providers on two web sites (www.hhs.gov/oig and http://exclusions.oig.hhs.gov/). Approximately 20,000 names are now included on the list, which is updated monthly. Providers can be placed on the list because of healthcare crimes (such as violation of federal fraud and abuse laws), license revocations or failure to repay federal health education assistance loans.

Physicians can take a number of steps to minimize the risk of violation of the federal law, including the following:

- Check the OIG web site prior to entering into any employment or service contract and periodically during the term of the contract and document their findings.
- Consult with counsel if an individual or entity is on the list of Excluded Providers.
- Include in contracts and employee handbooks provisions requiring notice and immediate termination in the event of exclusion.
- Require individuals and entities to certify that they are not Excluded Providers or under investigation by a federal healthcare program at the time of their employment or engagement and periodically thereafter.

Are You Ready for HIPAA?

By: Linda S. Ross

Physicians are among those subject to the "Standards for Privacy of Individually Identifiable Health Information" regulations issued on April 14, 2001 pursuant to the Health Insurance Portability and Accountability Act of 1986. The regulations govern the use and disclosure of Protected Health Information. They apply to health plans, health care clearinghouses and health care providers who transmit any health information in electronic form in connection with transactions covered by the regulations. For the most part, the regulations take effect on April 14 of 2003 and require a fair amount of compliance planning now. Penalties for the failure to comply include graduated fines and, in some extreme cases, imprisonment.

What is Individually Identifiable Health Information?

Individually Identifiable Health Information is health information created or received by a health care provider or others that relates to the past present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual, that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

What is Protected Health Information?

Protected Health Information is Individually Identifiable Health Information that is transmitted electronically and that is maintained in any form.

What do the Regulations Require of Physicians?

1. Consents. Physicians who transmit health care information electronically (or have it transmitted electronically on their behalf) generally must obtain a signed patient consent in the form prescribed by the regulations in order to use or disclose PHI in connection with treatment, payment or health care operations. For other uses, a patient authorization generally is required. A new consent is not required at each subsequent visit; rather, consent

NOTEWORTHY

On July 6, 2001 the Department of Health and Human Services, Office for Civil Rights (the "OCR") issued its first guidance regarding the Standards for Privacy of Individually Identifiable Information (the "Rule") promulgated under the Health Insurance Portability and Accountability Act of 1986 (the "Guidance"). The Guidance is in a question and answer format and can be located at http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm. The Guidance clarifies a number of points:

- A spouse, relative or friend is permitted to pick up a prescription for a patient.
- Physician' offices are not required to verify a patient's signature to the required consent if execution occurred outside of the health care providers' presence.
- Health care providers are not precluded from using bedside patient charts, X-ray boards and patient sign-in sheets in waiting rooms.
- Physicians' offices do not need to be retrofit through the installation of soundproof walls or private rooms.

Rather, physicians' offices must have in place appropriate administrative, technical and physical safeguards and maintain reasonable precautions to prevent inadvertent or unnecessary disclosures of Protected Health Information. Examples of reasonable safeguards include the use of barriers, such as curtains or screens, in areas where multiple patient-staff communications routinely occur. Future guidance will be issued by the OCR to modify inconsistencies in the Rule related to phoned-in prescriptions, first time referral appointments, allowable communications, the scope of the minimum necessary standard and the access rights of the parents to their children's medical records.

should be obtained at the time services are first provided. Significantly, a physician may condition the provision of care on the receipt of consent.

2. Notice of Privacy Practices. Physicians must prepare and provide to patients a Notice of Privacy Practices that describes in detail the uses and disclosures of PHI that may be made by the physician. The regulations specify what the Notice must contain. For example, certain words must appear at the top of the Notice, and the Notice must describe the physician's obligations regarding PHI and various individual rights of patients with respect to PHI. Examples of various types of uses and disclosures of PHI by the physician also must be included.

3. Individual Rights. Under the regulations individuals have the right to access and have copies of their PHI, the right to request receipt of PHI at a confidential location, the right to request restrictions in a physician's use or disclosure of PHI, and the right to request an amendment to his or her PHI. Additionally, subject to certain exceptions, individuals have the right to receive from physicians an accounting of the physician's disclosure of the individual's PHI. Physicians must develop policies and procedures to address these requirements.

4. Administrative Requirements. Physicians must designate a privacy official and contact person responsible for developing and implementing the physician's polices and procedures and for receiving complaints regarding the use or disclosure of PHI. Additionally, a physician must ensure that appropriate training with respect to the regulations is provided and documented at various intervals.

5. Business Associates. A business associate is a person or entity that performs services for or on behalf of a physician involving the use, disclosure or creation of PHI. In order to disclose PHI to a business associate (e.g., to a company that performs billing services on behalf of the physician), the physician must obtain satisfactory written assurances that the business associate will appropriately safeguard the information. In some cases, the physician can be held accountable for his or her business associate's failure to properly maintain the confidentiality of PHI.

Many physicians mistakenly think that these regulations do not apply to them. Although the regulations recognize that health care providers vary in size and resources and allow for a scaled approach to compliance, the requirements are complex and will require significant time and attention to ensure compliance. Physicians should consider conferring with counsel to assist in this process.

Honigman Miller Schwartz and Cohn is a general practice law firm headquartered in Detroit, with an additional offices in Bingham Farms and Lansing, Michigan. Honigman Miller's staff of more than 175 attorneys and more than 300 support personnel serves thousands of clients regionally, nationally and internationally. Our health care department includes the fourteen attorneys listed below who practice health care law on a full-time or substantially full-time basis, and a number of other attorneys who practice health care law part-time. Except as denoted below, attorneys in the health care department are licensed to practice law in the State of Michigan only.

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For further information regarding any of the matters discussed in this newsletter, or a brochure that more specifically describes our practice in health care law, please feel free to contact any of the attorneys listed above at our Detroit office by calling (313) 465-7000.

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