



HEALTH LAW

TICKED OFF



THE COLLECTION SERVICE MAY COME CALLING

Feds enlist extra help in identifying improper Medicare payments

By **PATRICK J. MONAHAN II**
and **WILHELMINA A. de HARDER**

In 2005, the Centers for Medicare & Medicaid Services (CMS) introduced a three-year demonstration project in California, Florida, and New York using Recovery Audit Contractors (RACs) to assist Medicare in identifying improper payments made to health care providers.

These private contractors were paid a contingent fee based on a percentage of overpayments recovered. The purpose of the demonstration project was to determine whether the use of RACs would be a cost-effective method to discover and correct improper Medicare payments. As of March 2008, RACs identified more than \$1.03 billion in Medicare improper payments (from a total of \$317 billion in Medicare claim payments available for review) at a cost of 20 cents for each dollar collected.

RACs analyze claims data using their proprietary techniques to identify claims that either clearly contain errors or likely contain errors, resulting in improper payments. RAC review claims involving physicians, hospitals, skilled nursing facilities, inpatient rehabilitation, clinical laboratories, and durable medical equipment. Improper payments generally result from lack of documentation to support the service/claim; non-covered services (including services that are not reasonable and necessary); incorrectly coded services; and duplicate services.

In the case of improper overpayments resulting from clear errors, RACs use a process called “automated review” to identify and recoup the overpayment amounts. For instance, RACs could use information systems to search for claims for two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. As duplicate surgical procedures are clearly not medically necessary, the hospital should not have billed twice and should not have been paid twice by the Medicare claims processing contractor.

RACs perform an automated review only when the improper payment was obvious, such as a duplicate

— SEE PAGE 6 —

Attorney general challenges controversial Lyme disease guidelines

By **ELLIOTT B. POLLACK** and **CHRISTINE COLLYER**

A generation ago, most physicians would have doubted that antitrust rules and the clinical practice of medicine could intersect. Attorneys were of the same view about their profession until 1975 when the U.S. Supreme Court decided *Goldfarb v. Virginia State Bar* and threw out minimum fee schedules on restraint of trade grounds.

Now, fast-forward 31 years to November 2006 when Connecticut Attorney General Richard Blumenthal initiated an investigation of the Infectious Diseases Society of America (IDSA). More particularly, the attorney general sought information about the development process of the IDSA’s 2000 and 2006 guidelines on the diagnosis and treatment of Lyme disease.

The investigation did not attack the science behind the guidelines but, rather, sought to determine whether IDSA engaged in exclusionary and monopolistic conduct during their development. Blumenthal’s inquiry was whether IDSA excluded

— SEE PAGE 4 —

ALSO INSIDE

GIVING BIRTH TO CONTROVERSY

More and more couples who cannot conceive are using surrogate parents to make their dreams of a family a reality. But state courts are in a state of disarray regarding the pre-birth agreements that accompany these arrangements.

SEE PAGE 2

ON ALERT FOR RED FLAGS

Don’t be surprised if your physician’s office requests photo identification at your next visit. Federal law requires businesses, including many health care providers, to establish identity theft prevention programs.

SEE PAGE 4

REFUSAL RIGHTS FOR PROVIDERS?

Forty-seven states, including Connecticut, have some sort of conscience clause legislation that protects the rights of health care providers that refuse to provide certain procedures or services for moral or religious reasons.

SEE PAGE 4

CRACKDOWN ON ‘EXCLUSION BILLING’

The federal government keeps a list of health care professionals and organizations that are excluded from billing Medicare, Medicaid and other federal health care programs. Federal authorities are pursuing those who continue to bill.

SEE PAGE 7

GETTING LOST IN TRANSLATION

Under federal law, most health care providers that take part in federal reimbursement programs must find ways to effectively communicate with patients who are hearing impaired or who speak limited English.

SEE PAGE 8

SURROGATE PARENTING GIVES BIRTH TO CONTROVERSY

Courts divided on how to handle cutting-edge reproduction issue

By **CHRISTOPHER M. GALLAGHER**

A gestational carrier agreement is an agreement covering the birth of a child through surrogacy, wherein an individual or a couple enters into an agreement with a woman to carry and give birth to their child.

In some cases, the two intended parents are the genetically related parents of the child to be born. In other cases, the intended parent or parents use an egg and/or sperm donor and therefore, at least one of the intended parents is not genetically related to the child to be born. In either case, counsel has brought complaints seeking the issuance of pre-birth orders pursuant to Connecticut General Statute §7-48a for genetic and non-genetic intended parents of children being carried by gestational carriers.

Currently, Connecticut is in a state of disarray regarding the issuance of these pre-birth orders by the Superior Court. For about

Christopher M. Gallagher is an associate in the law firm of Victoria T. Ferrara P.C., in Fairfield.

the past six months, the state Department of Health has objected to the Superior Court issuing orders unless the intended parents are genetically related to the child or the children.

At the Superior Court level, there is a split of authority regarding whether Conn. Gen. Stat. §7-48a, as written, allows this form of relief. The Connecticut Attorney General's Office, through the Department of Health and Judge John D. Boland in *Oleski v. Hynes* (2008), has advocated that the law only allows for a genetic parent to be named on a replacement birth certificate and that the correct procedure for a non-genetic parent to obtain parental rights is through a co-parent adoption in the Probate Court.

To the contrary, Judge Lloyd Cutsumpas, in *Griffiths v. Taylor* (2008), and an overwhelming number of Superior Court judges have advocated that Connecticut allows for a finding of intended parentage and have signed orders supporting the same. Recently, however, once these orders are issued, the state appeals the ruling of the Superior Court, thereby delaying the implementation of the Superior Court's order and leaving the gestational carrier as the legal parent.

This office currently represents two intended parents at the Appellate Court level (See *Raftopol v. Ramey*, et al). At the trial court level, Judge James G. Kenefick, granted the intended parents' petition for a pre-birth order and the state subsequently appealed. Because the intended

parents lived in Romania, they were unable to obtain jurisdiction for a co-parent adoption or enter into a same sex adoption based upon Romanian law. Accordingly, the non-genetic father has no legal parental rights until Appellate Court rules on the state's appeal.

Until the Appellate Court hears argument on these matters and issues a decision, no representations can be made regarding the ability of any attorney to obtain a pre-birth order without the matter being appealed. Even after the Appellate Court rules, the party denied relief can petition the Supreme Court. In the final analysis, the time frame for a binding ruling from a higher court could take more than two years.

Even with the difference in viewpoints, both the courts and opposing counsel to these actions agree that the correct manner to ad-



Christopher M. Gallagher

dress this issue is through the legislative process and not the courts. If the legislature does choose to address this issue, the constituency can then decide how best to clarify this legislation as opposed to judges, clerks and lawyers who attempt to infer intent through legislative histories. If the statute is not clarified, numerous issues will continue to serve as problems for parties to a gestational carrier agreement.

This office has lobbied legislators to clarify Conn. Gen. Stat. §7-48a. Rep. Thomas Drew (D-Fairfield) introduced House Bill 1137 which sought to clarify this law. The bill would authorize a court of competent jurisdiction to make a finding of intended parentage for parents of children conceived through assisted reproduction, and pursuant to a gestational carrier agreement. Currently, the bill awaits action by the state Senate. Hopefully, the legislature will take action to ensure that courts are provided with guidance in implementing these orders and are not subject to analyzing and interpreting legislative intent.

More and more individuals who either cannot conceive or cannot carry children to term are utilizing assisted reproductive clinics to make their dreams of a family a reality. To ignore this new and progressive field of medicine does a disservice to the children conceived through this form of technology and the intended parents who seek to raise their children in a loving home. ■

WATCHING OUT FOR THOSE WHO ARE INCAPACITATED

Subtle differences between 'health care representative' and 'conservator'

By **ANDREW S. KNOTT**

Whether an attorney handles estate tax planning or Medicaid planning, both types of work involve human beings as clients who require planning for sickness and incapacity. In recent years, our legislature has been tinkering with statutes covering this subject, causing a lack of understanding of the various health care documents—even amongst practitioners.

Let's start out with the basics: Under current law, an appointment of health care representative is the document that designates who will make medical decisions on another's behalf when that person is no longer capable to do so—to the exclusion of powers of attorney. A power of attorney allows a person to handle only financial transactions on behalf of another. This is a departure from the way things were done for many years when the power of attorney statutory form specifically included health care decisions, and it is still a source of confusion for some.

It must be noted, though, that a power of attorney that included health care decisions as well as the old "appointment of health care

agent" are still in full force and effect provided they were executed before Oct. 1, 2006. With these grandfathered documents, there is no need, legally speaking, to execute the new appointment of health care representative. However, practically speaking, hospitals and nursing homes sometimes look at you cross-eyed with an old power of attorney covering health care, so it's good to have the statutory citation that validates these documents handy: General Statutes, 19a-580f.

And then there are conservators. When explaining to clients the difference between a conservator and a health care representative, I quip: "A conservator is a health care representative on steroids."

Key Differences

For purposes of this article, a conservator of the person has all the authority of a health care representative. The key difference between the two is that a conservator is appointed by the probate court and acts as its agent, while a health care representative is appointed by the individual and acts as his agent without any court involvement.

Additionally, a conservator has a duty to act on behalf of the conserved person whereas the health care representative has the right, but not the duty, to so act. Oftentimes, a conservator is appointed because an existing health care representative is not exercising his right. But it must be noted that although the appointment of a conservator typically trumps any existing health care representatives in effect, it does not necessarily. The language of the probate court's decree of appointment should specify the authority which the court grants to the conservator; any authority that

is not specifically granted to the conservator is retained by the individual who is free to keep it or delegate it to anyone he may wish.

Also, an individual can execute a "designation of conservator," which is a document that requests that the probate court appoint a particular individual as conservator in the event the court is inclined to appoint one. In fact, the court pretty much has to appoint the designated individual unless there is good cause for an alternate appointment. Many clients ask why they should have a designation of conservator when they already are executing an appointment of a health care representative. The trite answer to that question is the need for redundancy due to Murphy's Law.

It should be noted that whenever a person is fulfilling his role as the medical decision-maker—in whatever form—it is emphatically not the job of such person to substitute his judgment for that of the incapacitated person. Rather, he must work to implement the wishes of the person for whom he is making decisions. This is where the living will comes into play.



Andrew S. Knott

Living Wills

Multiple levels of forethought are a telltale sign of competent legal work—especially with regard to a person's living will. However, what makes that document shine to a lawyer can make it unwieldy to a health care provider—those who apply the meaning of the document in an emergency.

Consider this situation: A patient is suffering from cardiac arrest and there is a five-page living will in the chart that has yet to be consulted. Does anyone really think that the living will would be consulted before any medical procedures are begun? And leaving that aside, at a Connecticut Bar Association Elder Law section meeting last year, a handful of practitioners mentioned that they encountered physicians who automatically assumed that a living will was a "Do Not Resuscitate/Do Not Intubate" order, which is flat wrong.

Consider another scenario: Dad has died, and Mom is failing to the point where she needs 24-hour care. The children move Mom to a nursing home, which would like to see her on DNR/DNI status, but the family disagrees. The nursing home consults the living will and interprets it as requiring DNR/DNI status. Each side lawyers up and the issue is forced on a probate judge to decide Mom's fate.

In both situations, the living will is interpreted by someone other than the health care representative—the person for whom the document is meant. It is for these reasons that I counsel clients to hold onto the living will and only provide it to the health care representative, so a health care provider takes direction from the health care representative, who in turn takes orders from the living will. ■

Andrew S. Knott, a partner at Knott & Knott LLC in Cheshire, is co-chair of the Young Lawyers Sections of the Connecticut Bar Association's Estates and Probate Committee.

HELPING CONSUMERS THROUGH THE MANAGED CARE MIRE

State advocacy office helps insured residents get the treatment they deserve

By VICTORIA VELTRI

Health reform and access to health insurance coverage are the talk of the state and the country. Extending insurance coverage to the tens of millions of Americans and the hundreds of thousands of Connecticut residents without it is certainly a widely shared goal—there are multiple bills under consideration in the state legislature that would move us much closer to that goal.

Nonetheless, we need to make it a priority to focus also on the many inconsistencies and barriers to care faced by consumers who are currently insured so we don't duplicate our mistakes on a systemic basis. Daily, Connecticut's commercially and publicly insured residents struggle to understand their insurance coverage, their financial responsibilities and how to challenge decisions that deny medically necessary care. The Office of the Healthcare Advocate (OHA) helps consumers navigate these confusing processes.

OHA is an independent, non-partisan state agency with one overriding mission: to provide assistance to consumers who may be confused about health care in general and

The Office of Healthcare Advocate is right in the middle of the medical necessity, claim denial and other health care battles. We fight for individuals like Claire who face death or serious illness.

need help in working through managed care issues. Since its inception, the office has provided free services to consumers in investigation of their complaints, appealing denials of coverage by insurance plans and assisting residents in the selection of plans. OHA pursues legislative or systemic remedies when individual casework identifies ongoing barriers to health care. State and national officials, and officials from other states, consult with our staff on a regular basis to discuss emerging federal health care issues and to seek our input on proposed legislation.

Cancer Case

One person who was caught in a managed care mire is Claire, a 63-year-old woman who thought her battle with breast cancer ended more than 15 years ago. Instead, it returned with a vengeance and she needed immediate treatment to save her life. She underwent major surgery, chemotherapy and radiation during her first go-around, but one of her lungs and her heart were affected by the massive doses of radiation. Her new and experienced oncologist suggested a

newer form of focused, higher-dose radiation treatment to prevent further damage to Claire's lungs and heart. The oncologist requested prior authorization for the treatment as required by Claire's insurer. An approval would guarantee that the insurer would not argue that the treatment was not medically necessary. A denial would guarantee a delay in treatment at best, or no treatment at worst. Claire, like many others before her, hit a major roadblock. Her insurer rejected the oncologist's request for prior authorization for the procedure, calling the procedure experimental and investigational, despite its frequent and effective use for repeat cancer patients with organ damage.

After OHA convinced the insurer to reopen Claire's appeal and to have an appropriately trained provider review the request based on Claire's individual circumstances, including the compromised status of her heart and lungs, the insurer overturned its denial. Claire started her focused radiation treatment the next day and is doing very well.

The overriding concern in managed health care is whether requested health care services or treatments are "medically necessary." The concept of medical necessity has been the subject of complex litigation and multiple pieces of state legislation to protect providers and consumers, and to reinvigorate and codify the deference due to health providers when they render care to patients. However, at its core it is an individual issue affecting individual consumers.

To be sure, insurers approve the majority of requested treatments. Sadly, however, Claire's experience with a denial of medically necessary treatment was repeated over 60,000 times last year for individual health care policyholders in Connecticut. Approximately 17 percent of the 358,000 advance requests for treatment last year were denied. These statistics do not include insurers' other denials of claims based on a lack of medical necessity for services or treatments that do not require advanced approval. Nor do they include data on claim denials for other reasons such as a patient's use of an out-of-network provider.

OHA is right in the middle of the medical necessity, claim denial and other health care battles. We fight for individuals like Claire who face death or serious illness in the mirror, and whose choices are limited to either doing everything they can to get their medically necessary treatment, or going without, because their insurers fail to look at them as individuals with unique circumstances. Nowadays, an insurer not paying for promised medically necessary care is tantamount to an actual denial of care.

Increased Demand

Skyrocketing health care costs, a rough economy, the clamping down on approvals of requests for health care coverage, and the escalating numbers of people requesting coverage for mental health services, surgical interventions and effective medications have only increased demand for the free legal, individual and systemic advocacy services that the Office of the Healthcare Advocate provides to Connecticut residents. We try each day to restore the balance between the consumer's need for health care, the provider's need for respect for his or her medical judgment and the need to control health care costs.



Victoria Veltri

Since 2001, OHA has assisted more than 8,000 people and returned \$14.5 million back to consumers when denials of care are overturned. Last year alone, OHA saved consumers \$5.2 million with an 85 percent success rate of getting care denials overturned. Referrals come to OHA from all areas of the state, from legislators, state agencies, our congressional delegation, hospitals, providers, and, most importantly, from previous consumers.

As general counsel for OHA, in addition to other duties, I have the responsibility of developing and advocating for the legislative agenda that we set each year. While we have several pieces of legislation moving through this year's legislative session, recently we succeeded in pushing these bills through the legislature or Congress:

- P.A. 08-125, eliminates an arcane legal requirement prohibiting coverage for mental health residential services unless one is at an acute or crisis level of care and is

in an acute hospital for three days prior to the residential treatment.

- P.A. 08-171, established a Commission on Health Equity whose mission is to eliminate "disparities in health status based on race, ethnicity and linguistic ability, and to improve the quality of health for all of the state's residents."

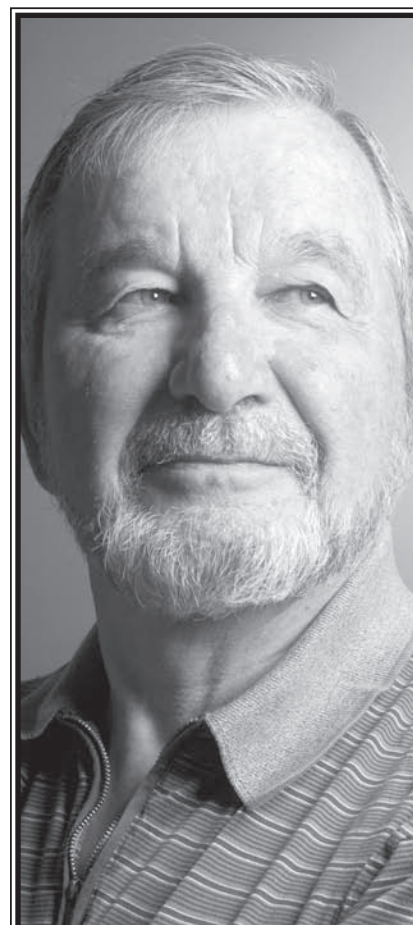
- P.A. 08-132, requires insurers to cover therapies for autism spectrum disorders to the same extent they are covered for physical illnesses.

- P.A. 07-75, incorporates a definition of medical necessity into the individual and group health insurance statutes.

- Domenici-Wellstone Mental Health Parity Act. For more information, see U.S. Sen. Christopher Dodd's comments in the *Congressional Record*: www.govtrack.us/congress/record.xpd?id=110-s20070918-53&person=300036

These "mini-fixes" reflected in legislation must be addressed as we take on a new health care system. One of OHA's near-term goals will be to outline the access-to-care issues insured residents now face so that these same issues are not perpetuated in any future model.

In Connecticut, if you or someone you represent is having difficulty selecting an insurance plan, getting approval for a service, challenging a denial or has general questions about health care or health care insurance, please call the State of Connecticut, Office of the Healthcare Advocate (OHA) toll-free at 1-866-HMO-4446 or contact us at www.ct.gov/oha for the help or information you need. ■



- ▶ Your client missed his last two appointments.
- ▶ His daughter calls you three times a day.

You know the law. We know elder care. We'll work with you to help your clients get the home care services they need.

We're the **Home Team of Care Management Associates**, providing professional care for a quarter of a century.

Call us at

860.654.2183

or visit

hometeamcare.org



Care Management Associates

A division of Connecticut Community Care, Inc.

Victoria Veltri is general counsel in the state's Office of Healthcare Advocate.

PROVIDERS MUST BE ON ALERT FOR 'RED FLAGS'

New federal law requires policies to prevent identity theft

By KRISTIN CONNORS and EDWARD SPINELLA

Do not be surprised if your physician's office staff requests photo identification at your next visit. Federal law requires certain businesses and organizations that extend credit, which includes many health care providers, to establish and enforce written identity theft prevention programs. These health care providers must be on the alert for "red flags" — patterns, practices or specific activities that indicate possible identity theft.

The Fair and Accurate Credit Transactions Act of 2003 (FACTA) directed financial regulatory agencies, including the Federal Trade Commission, to promulgate rules regarding the establishment of identity theft prevention programs. In November 2007, the FTC, along with other agencies, issued the "Red Flags Rule" requiring "creditors" and "financial institutions" with covered accounts to implement programs to identify, detect and respond to red flags

regardless of size and regardless of whether the health care provider is a for-profit or not-for-profit entity.

Amidst ongoing debate regarding whether the rule is written too broadly, the FTC has (for a second time) delayed enforcement until Aug. 1, 2009. On April 30, FTC Chairman Jon Leibowitz, stated in a press release: "Given the ongoing debate about whether Congress wrote this provision too broadly, delaying enforcement of the Red Flags Rule will allow industries and associations to share guidance with their members, provide low-risk entities an opportunity to use the template in developing their programs and give Congress time to consider the issues further."

The FTC also announced that the agency will soon release a "template" to help enti-



Kristin Connors



Edward Spinella

ties that have a low risk of identity theft — for example, health care providers who know their patients personally — comply with the rule. No further details regarding the template were immediately available.

after the completion of services, including for the balance of medical fees not reimbursed by insurance; or allows the creation of payment plans after the services have been rendered.

If, however, the health care provider requires payment in full before or at the time of service; or accepts only direct payment from Medicaid or similar programs; or accepts credit cards as the form of payment, then the health care provider is not a "creditor" and is not subject to the rule.

A "covered account" is an account used primarily for personal, family or household purposes that involves multiple payments or transactions.

'Suspicious Documents'

Red flags are a "pattern, practice, or specific activity that indicates the possible risk of identity theft." Examples of "Red Flags" include, but are not limited to:

- Alerts, notifications or warnings from a consumer reporting agency.
- Suspicious documents, such as a change of address notice, that is followed by a request for new credit or an application that appears to have been forged, altered, or reassembled.
- Suspicious personal identifying information, such as a Social Security number

■ Continued on PAGE 8

Covered Providers

The rule is applicable to *any entity* that meets the definition of "creditor" and maintains "covered accounts." A "creditor" is defined as any entity that regularly extends, renews or continues credit, or arranges for others to do so; and includes all entities that regularly permit deferred payments for goods or services.

The FTC considers a health care provider to be a creditor if the health care provider regularly provides services and bills patients

■ From TICKED on PAGE 1

legitimate but contradictory evidence and opinions on the existence of chronic Lyme disease. This is believed to be the first time a state has relied on antitrust principles to investigate a medical society's guideline process. However, it is not the first time that antitrust law has been used to challenge a medical entity's clinical stance.

In 1978, Dr. Chester Wilk and four other chiropractors sued the American Medical Association, among others, alleging Sherman Act violations because the AMA's rules prohibited allopathic doctors from referring patients to or even coordinating care with chiropractors. Nine years later, a U.S. District Court found that the AMA had tried to eliminate the chiropractic profession; essentially, it had orchestrated a group boycott. The court ordered the AMA to revise its rules. The Supreme Court upheld its decision.

It is not unusual for a professional medical organization to draft clinical guidelines. These guidelines pack a mighty punch because they are frequently employed to define the relevant standard of care. Doctors apply them in their practice and often base treatment decisions on them. Insurance companies rely on them to determine coverage and to deny reimbursement. State regulatory agencies use them in licensure and disciplinary proceedings against doctors.

The IDSA Lyme guidelines have had a sweeping impact on the diagnosis and treatment of Lyme disease, especially in Connecticut, a highly endemic area for the disease and whose quaint shoreline town gave the disease its name. Insurance companies such as United Healthcare, Health Net and others regularly rely on them to dispute the existence of chronic Lyme disease and to deny coverage for long-term antibiotic treatment. The Cen-

ters for Disease Control and Prevention lists the IDSA guidelines on its website. In three disciplinary proceedings before the Connecticut Medical Examining Board, the Department of Public Health has offered expert witnesses who espouse the IDSA guidelines in its prosecution of physicians who believe in and treat chronic Lyme disease.

Blumenthal's investigation caused a major stir in the medical community nationally. Some, like the Lyme Disease Association, applauded because it believed that IDSA had improperly excluded evidence about the existence of chronic Lyme disease. IDSA supporters argued that Blumenthal overstepped his bounds and was improperly interfering in scientific matters.

Two Schools Of Thought

A person unfamiliar with the controversy that surrounds Lyme disease and chronic Lyme disease might not understand the significance of the attorney general's thrust. Briefly, there are two schools of thought on the diagnosis and treatment of Lyme disease. Physicians adhering to the school reflected in the IDSA guidelines believe that Lyme disease is easy to diagnose and treat. They contend that short-term antibiotics are the appropriate therapy. They do not believe that chronic Lyme disease exists. They stress the importance of positive laboratory tests to confirm a Lyme disease diagnosis.

Physicians subscribing to the school reflected in the International Lyme and Associated Diseases Society's guidelines believe that the diagnosis and treatment of Lyme disease is complex. They maintain chronic Lyme disease is quite prevalent and may require long-term antibiotic treatment, sometimes intravenously. They dispute the accuracy and utility of available testing.

On May 1, 2008, Blumenthal announced

that his investigation uncovered "serious flaws" in IDSA's guideline process. He stressed that medical groups, such as IDSA, have both a "legal and moral duty to use exacting safeguards and scientific standards." The panelists who draft the guidelines must be free of conflict, he stated, and should not exclude divergent views unless unsupported by evidence. These were the very concerns of Lyme disease activists who brought IDSA's actions to Blumenthal's attention and who were the catalyst for his investigation.

Some of the serious flaws uncovered by the attorney general's office were: (1) panelists with undisclosed financial interests were not discovered because IDSA failed to conduct a conflict of interest review; (2) panelists refused to consider information concerning the existence of chronic Lyme disease and removed a physician who disagreed with the majority opinion; (3) IDSA blocked appointments of scientists and physicians who believed in the existence of chronic Lyme disease by telling them the panel was full even though it was later expanded; and (4) IDSA appointed a chairman who was so biased about the non-existence of chronic Lyme disease he used his position to appoint like-minded individuals without oversight committee approval.

Credibility Issues

These flaws called the guidelines' credibility into question. IDSA and the attorney general's office entered into a settlement agreement under which IDSA agreed to an extensive re-examination of its 2006 guidelines. A review panel will be created to "scrutinize" the guide-

lines to determine whether they should be updated or revised. None of the panelists who sat on the 2006 panel are permitted to serve again. IDSA must hold an open application process. All applicants are to be screened for potential conflicts by the ombudsman approved by the Attorney General's office.

After the new panel is established, it must hold an open scientific hearing, which has yet to be scheduled, to consider information from "interested parties" approved by the attorney general's office and the ombudsman. However, the hearing is not open to the public — which has raised some eyebrows in the Lyme disease community. In lieu of a public hearing, IDSA is required to broadcast the hearing on its web site. After the hearing, the reviewers will decide whether the 2006 guidelines are supported by the evidence.

It is too early to tell whether the "redo" demanded by Blumenthal will produce a different result. Lyme activists have expressed doubt that it will. The most important lesson of the attorney general's/IDSA settlement is that regulators can no longer be expected to hang back in the face of exclusionary practices by medical clinical standard-setting bodies. The credence given to IDSA's Lyme disease guidelines by regulatory, reimbursement and professional medical groups, coupled with the hostility showed by IDSA adherents to differing views, was dramatically exposed by the attorney general's efforts. Legislation is currently pending at the General Assembly addressing the Lyme disease controversy which will be the subject, if enacted, of a future article. ■

Elliott B. Pollack is a member of Pullman & Comley in Hartford where represents health care providers. Christine Collyer is an associate in the firm's Hartford office where she handles health care litigation. The authors represent a physician charged by the Department of Public Health with improperly diagnosing and treating Lyme disease.

DO HEALTH PROVIDERS HAVE 'RIGHT TO REFUSE'?

'Conscience clauses' allow hospitals to opt out of abortions, other procedures

By JENNIFER N. WILLCOX

Recent stories about pharmacists' refusal to provide contraception, and plans by President Barack Obama's administration to withdraw last-minute regulations on provider rights of conscience left behind by former President George W. Bush have put the issue of conscientious objection to health care treatment in the spotlight.

Technological advances often outpace our ability to develop ethical guidelines about how these technologies will be put to work, and the health care system must grapple with the collision between the individual rights of providers and the health care needs of patients.

Background

Almost before the ink dried on the *Roe v. Wade* decision, Congress responded in 1973 with the Church Amendment, which provides that the receipt of federal funds in various health programs does not require hospitals or individuals to participate in abortions if they object on moral or religious grounds. So-called "conscience clauses" after the Church Amendment have extended protection to other types of health care providers, and expanded the grounds on which such clauses can be invoked. The Hyde-Weldon Amendment of 2004 prohibits a government program from receiving certain federal funds if it "subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." (Public Law No. 108-447, § 508(d)).

States have been even more active in the arena of provider conscience protections,

and appear in the Public Health Code, and states that "no person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs." (Conn. Agencies Reg. § 19-13-D54) Some states (such as Arkansas, Delaware, and Florida) give an unfettered ability to individuals and institutions to opt out of any procedure that results in the "termination of a pregnancy," while other states place restrictions on the types of procedures to which providers can object or the types of institutions that can refuse to provide treatments.

More recently, states such as Arkansas, Georgia, Mississippi, and South Dakota have passed laws that explicitly give pharmacists the right to refuse to dispense drugs related to contraception, while others (California and Illinois) have passed laws mandating that pharmacies or institutions fill or dispense such prescriptions.

Some states, including Connecticut, require hospitals or other facilities to provide the "morning after pill" to rape victims who present for treatment, as long as certain requirements are met. (See Conn. Gen. Stat. § 19a-11e (Public Act 07-24)).

A few states have expressly adopted "conscience protections" that go beyond abortion and contraception. Maryland's "conscience clause" legislation extends to artificial insemination as well as sterilization and termination of a pregnancy. States such as Indiana, Pennsylvania, Idaho and Texas provide some protections for health care providers who refuse on moral grounds to implement the instructions of patients regarding end-of-life issues.

Case Law

Several cases have addressed the intersection of providers' conscience rights and the needs of patients. In *Doe v. Bolton*, a companion case to the better-known *Roe v. Wade*, the Supreme Court reviewed a Georgia statute that, among other things, required a panel of three physicians to approve all abortions.

Speculating that the provision was to protect the hospital, rather than the woman's informed choice, the court noted in dicta that "the hospital is free not to admit a patient for an abortion. . . . Further a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure." (410 U.S. 179, 197-198 (1973)).

There have been myriad cases involving moral or religious refusals to withdraw life-sustaining treatment, from the New Jersey Supreme Court's decision in *In re Quinlan* (355 A.2d 647 (1976)), to the 2006 controversy about Terri Schiavo, the severely brain-damaged Florida woman whose husband and parents fought in court over whether she should be taken off life support.

Most cases conclude that an otherwise competent adult has the right to refuse medi-



Jennifer N. Willcox

cal intervention and life-sustaining treatment, even if the institutional and individual caregivers involved object. Many cases, however, balance the health care provider's or facility's right to conscience against the individual patient's interests, and require that the objecting provider assist in transferring the patient to another provider that will carry out the patient's wishes. (See *Brophy v. New England Sinai Hospital Inc.*, 497 N.E.2d 626,633 (Mass. 1986)). Recent cases also have imposed damages for failure to follow a patient's instructions that were contrary to the moral or ethical beliefs of the provider. In Texas, a jury imposed a \$42 million verdict on a hospital for disregarding parental objections and providing life-sustaining treatment to a premature infant born after 23 weeks of gestation. On appeal, the verdict was overturned. (*Miller v. HCA*, 118 S.W.3d 758 (Tex. 2003)). And last summer, the California Supreme Court concluded that the state's anti-discrimination laws prevent physicians from

refusing, on religious grounds, to provide in vitro fertilization to same-sex couples. (*North Coast Women's Care v. Benitez*, Ct. App. 4/1 D045438).

New Federal Regulations

On Aug. 21, 2008, the Department of Health and Human Services issued a proposed regulation that would deny federal funding to any hospital, clinic, health plan or other entity that "subject[s] any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for, abortion."

An earlier draft of the regulation that was leaked to the media included language that defined abortion (for the first time in a federal law or regulation) as anything that interferes with a fertilized egg after conception. That language was deleted, but commentators said that the final regulations were broad enough to protect health care providers who decline to provide oral contraception, the "morning after" pill and other types of contraception.

Industry officials and state and federal legislators called for the rule to be withdrawn, and Connecticut Attorney General Richard Blumenthal brought suit to block its implementation. Shortly after Obama took office, the Department of Health and Human Services issued a proposal that would rescind the provider conscience regulations. Comments were due by April 9, 2009, and a final rule has not yet been issued. Until the "Rescission Proposal" is finalized, the Bush administration regulations remain in effect. ■

Maryland's 'conscience clause' legislation extends to artificial insemination and sterilization. Pennsylvania provides some protections for health care providers who refuse on moral grounds to implement the instructions of patients regarding end-of-life issues.

and have taken widely varying approaches to addressing the problem. At present, 47 states have some sort of conscience clause legislation that protects the rights of health care providers (individuals or institutions) that refuse to provide certain procedures or services; Alabama, New Hampshire and Vermont have no such statutes. These laws vary in the types of providers covered, the nature of the procedures to which providers may object, the process that must be followed, and the permissible grounds for refusal.

The majority of state conscience clause legislation addresses abortion or abortion-related procedures. Connecticut's protec-

Webster's Attorney Package.

Webster offers a tailored package of financial services to help you manage costs and run your practice more efficiently. We offer your firm business checking options suited to your needs, *no-fee IOLTA Checking*¹, and competitive rates on business loans and lines of credit² to manage your firm's cash flow, and sub-accounting to monitor all your clients' funds. And our Bank at Work program offers WebsterOne Relationship Checking³ for all of your employees.

Open your IOLTA Checking account with Webster Bank today. For more information contact Jordan Arovos at 203.782.4656 or via email at jarovas@websterbank.com.



WebsterOnline.com

Voted best bank for attorneys to do business with by the readers of the Connecticut Law Tribune.

¹ IOLTA Checking - Miscellaneous fees may apply.

² All credit products, pricing and overdraft protection are subject to the normal credit approval process. Some applications may require further consideration and/or supplemental information. Certain terms and conditions may apply. SBA guaranteed products may also be subject to additional terms, conditions and fees.

³ WebsterOne Relationship checking: minimum opening deposit of \$50 required. Normally there is a \$15 (or \$13 with direct deposit) monthly service charge if combined monthly average balance of \$4,000 in checking, savings or money market accounts or \$20,000 in combined deposit (checking, savings, CDs or money market) or home equity and installment loan balances is not maintained. This fee will be waived as long as your employer remains a Webster Bank at Work customer. Direct deposit of your paycheck is also required. Miscellaneous fees may apply. Webster will not charge any fees for using non-Webster ATMs and will rebate you if another financial institution charges you a fee for using its ATM.

The Webster Symbol, Webster Bank and Webster We Find a Way are registered in the U.S. Patent and Trademark Office. Webster Bank, N.A. Member FDIC. Equal Housing Lender.

UNDERSTANDING HOW TO DEAL WITH OVERPAYMENTS

Practices obligated to return undeserved federal funds

By **ANDREW P. GAILLARD**
and **HELEN HADLEY**

One of the more difficult questions confronting health care providers and their counsel is how best to handle what we will call “overpayment” situations. Those are situations where it is discovered that the provider has received payments it should not have. There are a variety of overpayment situations that can arise. Some are a result of minor billing or coding errors, while others may be the result of a long-running fraud. Many will fall somewhere between these two extremes.

Identifying the extent of such overpayments is generally time-consuming and expensive. And then even, once they are fully identified and understood, there are a variety of ways to resolve them. While there is often no clearly “right” way of handling the overpayment, there are most certainly “wrong” ways. Given the potential pitfalls of mishandling such situations — including termination of provider status, civil penalties and damages, criminal charges, and even exclusion from Medicare and other healthcare programs — overpayment situations must be handled very carefully.

How To Identify Them

It is obviously preferable that the provider office identifies overpayments itself rather than learn of them via insurance company audits, government inquiries, whistleblower actions, or other third parties. To this end, practices and their billing managers should

be diligent in watching payments received from payers, especially Medicare. Just because a payment has been made does not necessarily mean it was paid correctly. Ultimately, the practice is responsible for billing and coding services accurately, and has the obligation of returning funds when the claim is paid incorrectly.

Keeping a close eye on “Explanation of Benefits” is the first step in identifying overpayments. Every claim that is paid incorrectly warrants investigation, but overpayments may have resulted from duplicate claim submission or submission of the incorrect service (CPT code). Running regular “credit balance” reports may reveal overpayments that have been posted and not yet resolved. Investigating the credits can uncover myriad issues.

Overpayments may unwittingly have occurred when a practice learns that it has been coding services incorrectly. This can happen when: (1) the providers are selecting a higher level of service than was rendered, (2) the wrong CPT code was selected, or (3) the service should not have been billed at all. Each of these billing/coding errors is serious, and suggests that the providers and staff have not educated themselves on appropriate coding and billing procedures. Periodic training, as well as routine reassessment or review of the practice’s procedures and systems, are important means of avoiding overpayments in the first place.

When counsel or consultants are engaged by a provider group, overpayments can be uncovered by running the credit reports, reviewing a sampling of “Explanation of Ben-



Andrew P. Gaillard



Helen Hadley

efits,” and interviewing staff. Specialty-specific requirements and rules should be discussed with the practice to determine if billing personnel have the knowledge that promotes clean claims

and proper billing. Counsel and consultants will want to regularly reference the Department of Human Services’ Office of the Inspector General’s “Work Plan and the Local Medical Review Policies” in an effort to prepare for these discussions.

What To Do With Them

Once an overpayment situation is identified, the obvious question is what to do about it. The provider’s first reaction may be to ignore the overpayment altogether, and hope it never comes up. When the amounts are small, and the costs of identifying them, repaying the various payers, and fixing the provider’s books, are high, the temptation will be strong to hope the problem goes away by itself. This is never a good option. The fact is that the provider has received funds that belong to someone else. If a payer, especially a government payer, discovers the problem and then learns the provider knew of it but decided to ignore it, the consequences are certain to be more severe.

In the simplest situations, where the overpayment is the result of a billing or coding error that has been caught and corrected by the provider, repayment of the funds to those who overpaid them is relatively straightforward. Medicare contractors have an overpayment form and a process for practices to use for repaying overpayments. If there is a

Medicare overpayment, odds are there will also be private payer overpayments which should also be resolved via repayment. These situations, particularly when the amounts are small, can be made with a very general explanation. Counsel and the provider should anticipate and have a more careful explanation in hand, however, should any payers seek more details.

More significant dollar amounts, particularly if there are factors that suggest impropriety on someone’s part, may be best resolved via the Office of Inspector General’s self-disclosure protocol (see the OIG web site, <http://oig.hhs.gov/fraud/selfdisclosure.asp> for details).

In recent years the Office of the Inspector General has sought to promote voluntary compliance efforts by the provider community by rewarding those who self-disclose with lesser financial penalties. The office has a specified format and procedure for the self-disclosure, but great care must be taken to fully and accurately describe the issues. Opening the door to the Office of the Inspector General is a serious step, and inaccurate or incomplete disclosures will only make the situation far more problematic and difficult to resolve.

If the overpayment situation involves substantial amounts of money, and/or the underlying facts indicate clear-cut fraud on someone’s part, the best course may be to self-report the situation directly to the U.S. Attorney’s office. This course should only be taken when it is clear the matter will be of interest to civil and criminal health care fraud prosecutors. This tactic requires a very carefully thought out proposal for what the “end game” should look like. The end result will certainly be painful, but almost certainly less painful than the outcome if the government learns of the situation through a whistleblower or one of the other means described above.

Conclusion

Overpayment situations are legal minefields. It is possible to navigate them carefully and safely. But they can also severely harm, or even destroy, the careless or unwary. ■

■ From WHEN on PAGE 1

claim, or when there is a deviation from a written Medicare policy, Medicare article, or Medicare-sanctioned coding guideline that precisely describes the coverage conditions.

Complex Review

In the case of claims that likely contain errors, RACs generally request medical records from the provider to further review the claim. Based on a review of the record, RACs make a determination as to whether payment of the claim was correct or whether there was an overpayment or an underpayment. This process is called a complex review.

Although there is no way to forecast which providers will be targeted for review,

certain types of claims and certain types of providers may see more RAC auditing activity than others.

During the demonstration program, 85 percent of overpayments were collected from inpatient hospital claims; 6 percent from inpatient rehabilitation facility services; 4 percent from outpatient hospital claims; and the remaining from physicians, skilled nursing facilities, durable medical equipment suppliers and ambulance, laboratory or other providers. Most overpayments occurred when providers submitted claims that did not comply with Medicare’s coding or medical necessity policies.

RAC In Connecticut

The Tax Relief and Health Care Act of

2006 made the RAC program permanent and required that the Centers for Medicare & Medicaid Services to implement the program in all states by Jan. 10, 2010. Based on the most recently published schedule, the RAC program could begin in Connecticut by Aug. 1, 2009. Before RACs begin their auditing activities in Connecticut, provider outreach programs, including educational meetings and town hall gatherings, will be conducted in late June or July.

There are a number of steps that providers (with assistance from their counsel) can take to prepare for a possible audit.

First, a provider’s staff should attend outreach programs in the provider’s area. The Centers for Medicare & Medicaid Services contact person for Connecticut (Region A) is listed as Ebony Brandon (410-786-1585). During these educational meetings (or shortly thereafter), providers will likely have an opportunity to identify the precise address and contact person to whom the RAC should send any medical record re-

quest letters or other correspondence.

Second, the provider should assemble a team to develop a process for handling RAC audits. The provider should consider involving counsel in this process so that nothing falls through the cracks. The provider should identify the RAC in Connecticut and watch for correspondence from that company. The RAC for Connecticut (Region A) is Diversified Collection Services (1-866-201-0580).

Third, the provider should be educated on RAC response times and have a system in place to monitor such times. RAC deadlines are strict and failure to file timely appeals will prevent an appeal of an improper denial.

Fourth, a provider and its legal counsel should keep current with Centers for Medicare & Medicaid Services announcements and other pertinent publications, which can help guide compliance efforts. In conducting reviews, RACs are guided by Medicare policies, regulations, national

■ Continued on PAGE 7

For more than 20 years, Patrick J. Monahan II has represented hospitals, businesses, and other clients in corporate and regulatory compliance matters, government relations, and litigation. He is the partner in charge of the Stamford office of Garfunkel, Wild & Travis P.C. Wilhelmina A. de Harder, an associate with the firm’s Litigation and Arbitration Practice Group, advises clients on a range of health care related litigation and compliance issues.

GOVERNMENT CRACKS DOWN ON 'EXCLUSION BILLING'

Providers must screen employees to ensure eligibility for federal funds

By MAUREEN WEAVER
and JODY ERDFARB

"Exclusion billing" is now a government enforcement priority, warned Assistant U.S. Attorney Richard M. Molot at a November 2008 Health Care Enforcement Roundtable sponsored by Wiggin and Dana. Exclusion billing is the unlawful billing of Medicare, Medicaid and other federal health care programs for services provided by individuals or entities, including employees or contractors, that are excluded from participation in federal health care programs. Molot said that Connecticut has seen an uptick in investigations into exclusion billing, and whistleblowers have alerted the government to many of these cases.

Who are excluded individuals and entities? The U.S. Department of Health and Human Services' Office of Inspector General is required to exclude individuals or entities under certain circumstances, such as upon conviction of a criminal offense related to the delivery of an item or service under Medicare or of certain drug related felonies. The inspector general has sweeping permissive authority to order exclusion in a variety of other circumstances, including fraud, breach of fiduciary responsibility, financial misconduct, unlawful kickbacks, or interference or obstruction of a criminal investigation.

How can excluded individuals and entities affect health care providers? The Balanced Budget Act of 1997 authorized the inspector general to impose civil monetary penalties on any business that employs or contracts with excluded individuals or entities to provide services or supplies that are reimbursed by federal health care programs. Penalties for exclusion billing can include fines of up to \$10,000 for each billed item or service furnished by the excluded individual or entity, recoupment of reimbursement received for such services, civil monetary penalties of up to three times the amount of the claims submitted, and program exclusion. In some cases, providers may face liability under the federal False Claims Act.

How is the law enforced? At the Health Care Enforcement Roundtable, Molot dis-

cussed an exclusion billing settlement involving Walnut Hill Care Center, a skilled nursing facility based in New Britain. In 2005, Walnut Hill hired a nursing supervisor. After the nurse's license was revoked in another state, the facility learned that she had been excluded from Medicare and Medicaid. After a lengthy investigation into potential False Claims Act liability, Walnut Hill, without admitting any wrongdoing, entered into a civil settlement with the government, paying \$222,419, and also entered into a Certification of Compliance Agreement with the Office of the Inspector General.

More recently, the Connecticut U.S. Attorney's Office announced an exclusion-related settlement with Silver Hill Hospital, a psychiatric hospital in New Canaan. In 2004, Silver Hill hired a full-time registered nurse. Although the nurse's Connecticut license had recently been reinstated, she still appeared on the inspector general's exclusion list. Silver Hill employed the nurse for four years before learning that she was excluded. Without admitting liability, Silver Hill settled for \$60,338.

What can health care providers do? Providers and their counsel can take a few simple steps to mitigate risk:

Check government exclusion data bases for all prospective employees and contractors. Every health care organization's corporate compliance program should contain a policy and procedures addressing exclusion. The policies should require that all prospective employees and outside contractors be screened against the Office of the Inspector General's List of Excluded Individuals or Entities, available at www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp and the U.S. General Services Administration's Excluded Parties List System, available at www.epls.gov/. The Connecticut Department of Social Services also requires that prospective employees and outside contractors be screened against the state Administrative Action List, available at www.ct.gov/dss/.

Develop a policy and practice for regular exclusion updates. In addition to checking state and federal databases upon hire or prior to entering into contracts, providers should require that exclusion databases be checked on a regular basis to determine whether current employees or contractors have been excluded. Policy and procedures should also address training of human resources staff on exclusion billing and on the process for regular exclusion checks. Federal officials have not made any formal recommendation

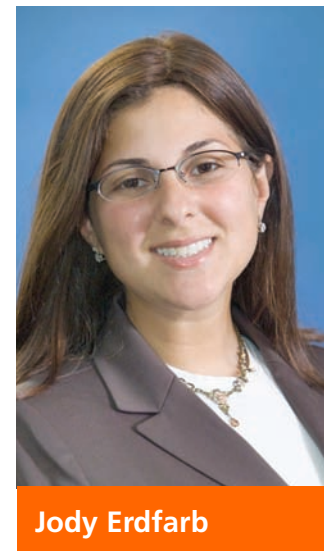
about how frequently providers should conduct exclusion checks. Some providers perform them quarterly; others check twice a year. Government officials have indicated informally that screening should occur

systematically *at least* annually. Providers should decide on a time frame, incorporate it into policy and check the databases regularly. Evidence that a provider conducted regular checks can be crucial to avoiding or mitigating penalties if it is discovered that an excluded individual was on the employment rolls, or that one of the provider's vendors is excluded.

Address exclusion in contracts. Agreements with outside contractors should include provisions addressing: (1) the contractor's representation that neither the entity nor any of its employees are excluded and guarantee that periodic exclusion checks are



Maureen Weaver



Jody Erdfarb

performed to ensure continued compliance; (2) the contractor's responsibility to notify the provider if the contractor or any of its employees are excluded; and (3) the provider's right to immediate termination in the event the contracting entity is excluded.

Take immediate action if an employee or contractor appears on the exclusion list. If an employer learns that an employee or contractor appears on the exclusion list, it is best to consult with counsel. The first step may be to immediately stop any billing for services provided by the employee or contractor. There are many complex rules for calculating when exclusion takes effect and how long after that date claims may still be processed. In most circumstances, an internal review followed by self-disclosure to the government is the recommended course. ■

Maureen Weaver is chair of the Executive Committee and a partner in the Health Care Compliance Practice Group at Wiggin and Dana LLP. Jody Erdfarb is an associate in the firm's Health Care Compliance Practice Group.

■ Continued from PAGE 6

coverage determinations and local coverage determinations. In instances where there is no Medicare policy, RACs review claims based on accepted standards of medical practice at the time of the claim's submission.

In addition, review of Office of Inspector General and Comprehensive Error Rate Testing reports indicates where improper payments have been found, and by reviewing this information, a provider can be proactive and correct or improve areas of potential concern prior to being subject to an audit.

Fifth, providers should work with coun-

sel to properly draft appeals to challenge denials. Under the RAC program, providers will have the same appeal rights they would have if Centers for Medicare & Medicaid Services or a carrier or fiscal intermediary identified the alleged overpayment.

Providers subject to RAC (as well as other Medicare audits and claim denials) may have a number of strategies available to them during the appeals process to overturn or limit an adverse decision. In addition to advocating the merits of a claim, various legal defenses are available that have proven valuable for providers challenging Medicare audit determinations. ■



Presented by

RisCASSI & DAVIS, P.C.
Protecting the Rights
of the Injured Since 1955

For many years, we at RisCassi and Davis have been privileged to help support Coach Jim Calhoun's charitable work throughout Connecticut. On Saturday, June 13th, Coach will be riding in his annual event to combat cancer – the Jim Calhoun Cancer Challenge Ride. We encourage all of our colleagues, their families and friends to register to ride with Coach on June 13 in Simsbury. The Ride benefits The Carole and Ray Neag Comprehensive Cancer Center at the University of Connecticut Health Center and Coaches vs. Cancer. Please help Coach stop cancer now. Register to ride, donate or volunteer at www.calhounride.com today or call 860-674-1500 for more information.

RisCASSI & DAVIS, P.C.
Protecting the Rights of the Injured Since 1955

131 Oak Street, Hartford, Connecticut 06126 • 860.522.1196 • www.riscassi-davis.com

DOCTORS' EXPLANATIONS CAN'T GET LOST IN TRANSLATION

Laws mandate sign language, foreign language interpreters

By **LISA M. BOYLE**
and **B. MOSES VARGAS**

Federal law prohibits certain health care providers from denying care to patients based on their need for language assistance. The Americans with Disabilities Act prohibits providers that offer care in a place of public accommodation from denying services to individuals because of their disability. Hospitals, physicians' offices, health centers and other health care providers that accept patients from the general public are considered places of public accommodation under the ADA. In addition, Title VI of the Civil Rights Act of 1964 says that health care providers that receive federal financial assistance, other than only Medicare Part B payments, cannot deny individuals with limited English proficiency meaningful access to health care services based upon their inability to speak English.

To provide appropriate care, health care providers must be able to communicate with patients who are hearing impaired or who speak limited English. What's difficult for providers covered by the ADA and/or Title VI is ascertaining the effort they must make to facilitate this communication. Recent case law and other guidance suggest that the burden on a provider may be considerable and that the size of the provider will rarely provide an exemption.

Sign Language Interpreters

Under the ADA, providers cannot deny services to hearing impaired patients simply because they do not have language assistance (i.e. qualified interpreter, note taker, etc.) readily available to effectively commu-

nicate with the patient. The ADA also prohibits providers from passing the cost of the language assistance on to the patient.

However, the ADA does not require a sign language interpreter every time services are provided to a hearing impaired patient. Providers are required only to ensure that hearing impaired patients are able to effectively communicate with their health care provider. How the provider accomplishes that is not mandated by the ADA; but if the communication is determined to be ineffective, the provider's choice will be subject to scrutiny and a violation of the ADA may be found. To determine what sort of language assistance is appropriate, providers should consult with the patient, take into consideration the patient's abilities, and recognize that the type of language assistance will likely vary depending on the nature and complexity of the communication involved. A more complex communication (i.e. pre-surgery instructions or informed consent) would likely require the provider to obtain a sign language interpreter, whereas the use of written notes would likely suffice for simpler communications (i.e. routine examinations).

Small providers and solo practitioners have argued in court that providing language assistance is financially burdensome, especially in light of decreasing reimbursement rates from government and commercial payors. The ADA says that if a health care provider demonstrates that offering language assistance would fundamentally alter the nature of the services being offered or result in an undue burden (i.e. a significant difficulty or expense), then the provider can substitute an alternative type of language assistance, if one exists. In determining whether the language assistance would cause an undue burden, providers need to consider, among other things, the nature and cost of the language assistance needed and the provider's overall financial resources. While this may suggest that small providers will not be required to hire a sign

language interpreter for a patient, a New Jersey case recently demonstrated how difficult it is for providers to demonstrate an undue burden. The court in *Gerena v. Fogari* held that it was not an undue burden for

a solo physician to pay more for a sign language interpreter than he was receiving from the patient's insurer. While this case may be an aberration, it highlights that all providers must ensure appropriate communication with hearing impaired patients.

Foreign Language Interpreters

Title VI requires health care providers to provide patients with limited English proficiency with meaningful access to their services. A provider must apply a four-factor analysis to determine what language services it must provide to patients. The provider must consider: (1) number or proportion of limited English proficiency patients served or encountered in the geographic area; (2) frequency with which these types of patients are served; (3) the nature and/or urgency of the provider's services (i.e. emergency surgery, routine examinations, etc.); and (4) a provider's available resources and costs.

Specifically, a health care provider must consider the predominant languages spoken in the area served and the number of patients speaking only those languages. For example, a provider in an area with a significant population of Chinese-speaking individuals may be required to provide Chinese-speaking



Lisa M. Boyle



B. Moses Vargas

interpreters. In other geographic areas, Spanish may be the predominant language and Spanish-speaking interpreters may be required.

Smaller providers with limited budgets are not expected to provide

the same level of language services as larger providers with greater resources. A provider offering only outpatient services has a lesser burden than a hospital. If the service being offered is not urgent, and the provider's resources and frequency of contact with low English proficiency patients are low, then such providers may not be required to employ staff interpreters. Instead, the provider could use telephonic interpreter services or share language assistance services with other providers. Health care providers have the burden of determining the level to which language services are necessary and reasonable and of providing such services in a timely manner.

Providers often have patients who want to use a family member or friend as their interpreter. In these circumstances, providers need to inform the patient that he has the option of receiving outside interpreter services at no cost. A provider cannot rely on the patient's family or friends to provide interpreter services if the patient wants an independent interpreter. If a friend or family member is suggested as an interpreter, the provider must consider whether the interpreter is competent, appropriate, will maintain confidentiality, and whether the interpreter has a conflict of interest. If the interpreter is determined to be inappropriate, the health care provider should strongly recommend the use of an independent interpreter.

Providers have some flexibility in determining whether they have to provide sign language and foreign language interpreters for patients. Under both the ADA and Title VI, providers are allowed to consider their resources when determining how to ensure meaningful access. The predominance of patients speaking a particular foreign language in the community will increase the obligation of the provider. In both cases, covered providers should have a process in place for obtaining some type of language assistance for its hearing impaired and low English proficiency patients. As for sign language interpreters, recent case law suggests that the bar is high for demonstrating that the provision of sign language interpreters for hearing impaired patients would be an undue burden. Providers must identify the language needs of their community and patients and be prepared to provide appropriate assistance. ■

■ From PROVIDERS on PAGE 4

that matches a Social Security number submitted by another person;

- Unusual use of, or suspicious activity relating to, a covered account, including the use of an account that has been inactive for a long period of time
- Notices from customers, victims of identity theft, law enforcement authorities, or other businesses about possible identity theft in connection with covered accounts.

Continued Debate

Various groups representing organized medicine, such as the American Medical Association, continue to debate the FTC on the application of the rule to health care providers.

The AMA claims the rule burdens health care providers by duplicating preexisting identity theft provisions found in regula-

tions adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA). Federal officials counter the rule is flexible and only calls for reasonable and effective measures, adding that the rule deals with patient accounts while HIPAA deals with medical records.

Health care providers should not risk fines of up to \$3,500 per violation while this disagreement is unresolved. Identity theft detection and prevention programs must be put in place by the Aug. 1, 2009 deadline.

Health care providers that extend credit should implement a written identity theft policy to detect, prevent, and mitigate identity theft. The rule allows covered entities to design and implement reasonable policies and procedures that reflect the size, complexity, and environment of each particular business.

In an official letter to the AMA, the FTC noted that a small medical practice with a

regular and limited patient base might be justified in adopting a "more limited program" than a large metropolitan clinic that serves a high volume of patients. In the case of a larger sized health care provider, the provider's board of directors must approve the policy.

Regardless of the provider's size, several general compliance actions should *always* be taken. These include:

- Create a written identity theft prevention policy.
- Train employees with respect to the policy.
- Identify red flags relevant to your practice.
- Establish procedures to respond to red flags (including when a response is *not* needed and documenting the reason for the decision).
- Periodically update the identity theft prevention program.
- Assess the identity theft prevention program.

Health care providers should note that while the rule is flexible and calls for reasonable efforts, each "creditor" will be held accountable for the overall effectiveness of the customized program. ■

Kristin Connors is a partner in Carmody & Torrance's litigation group where she has extensive experience in health care litigation. Edward Spinella is an associate in the firm's business services group.

Lisa Boyle is a partner and the chair of Robinson & Cole's Health Law Group. She represents health care providers in regulatory and transactional issues. Moses Vargas is a member of Robinson & Cole's Health Law Group.