

**RE: The Health Care Carrier Accountability Act and Inspector General Warning Against Unethical Practices of Business Consultants**

Dear Health Care Provider:

The constant changes in the health care landscape and the increasing demands placed upon providers can be overwhelming. In an effort to assist our clients to navigate the complexities of the health care industry, we are pleased to offer this update on current issues about which you should be aware. Our concise, *non-legalistic* explanations will help you to stay abreast of important developments without spending an inordinate amount of your time assessing whether or how laws and issues will affect your practice.

**The Health Care Carrier Accountability Act**

The scenario is familiar: a patient claims to have suffered harm because an important diagnostic test was not performed or a potentially life-saving treatment was unreasonably delayed or denied by his or her HMO. Who traditionally has been served with a Complaint and forced to mount a defense in the malpractice suit? The physician, not the HMO responsible for the medical decision to forego the test or authorize only the cheaper, less-effective course of treatment. The Health Care Carrier Accountability Act is a pivotal piece of legislation that will likely change the current landscape and, finally, hold carriers responsible for their role in medical decision-making.

Acting Governor DiFrancesco, whose signature will soon transform the bill into law, called the bill one of the strongest consumer protection bills in the nation. The law, which applies only to state-regulated health plans, creates seven categories of harm for which an HMO can be held liable: 1) death; 2) serious and long-term impairment of a bodily function or system; 3) loss of a necessary organ; 4) loss of a member; 5) exacerbation of a serious or life-threatening disease or condition; 6) chronic pain conditions; or 7) other substantial physical or mental harm.

Individuals who have suffered (or will imminently suffer) serious harm as a result of a plan's negligence in denying or delaying medical treatment may sue the offending carrier without pursuing the carrier's internal appeals process. However, before filing suit under the sixth and seventh categories of less-serious harm, patients will be required to exhaust an administrative appeals process before taking the carrier to court. Patients will be required to produce a physician's affidavit indicating a reasonable probability that the plaintiff's injury resulted from the health plan's negligence.

Under the bill, any employees, agents or representatives under the control of the carrier will be responsible for their treatment decisions. Furthermore, the bill prohibits health service contract provisions that attempt to limit or waive a carrier's liability. Thus, provisions that shift the carrier's exposure to providers will be void in contracts that are executed or renewed after the bill is officially passed.

The law will take effect ninety days after enactment. With no cap on punitive damages, carriers cannot easily "write off" lawsuits as a cost of doing business. Instead, the bill's supporters hope that the carriers' increased exposure will result in a restoration of the physician's power of discretion in treatment decisions.

## **Inspector General Warns Against Unethical Practices of Some Business Consultants**

Over the last several months, the Office of the Inspector General (“OIG”) has dramatically increased its prosecutions of health care fraud. Recognizing that much of this fraud is attributable to advice given by unscrupulous business consultants who profit from arranging business deals, legal or not, the OIG released an advisory opinion on June 27, 2001 that advises health care providers to be wary of unscrupulous business consultants who engage in unethical business practices. Some examples of unscrupulous business practices by consultants include:

- making illegal or misleading representations about their affiliation with or endorsement by government agencies such as the Centers for Medicare & Medicaid Services (formerly HCFA);
- promising or guaranteeing improbable results and submitting false claims or preparing false cost reports to effectuate the promised results;
- assuring a client that an appraisal of a practice will yield a fair market value that satisfies the client’s need for a particular valuation, regardless of the actual value of the practice;
- encouraging abusive practices, such as the use of improper billing codes to boost reimbursement or disguising double billings and claims for medically unnecessary services;
- encouraging providers to enter into business relationships that violate anti-kickback and self-referral laws and regulations.

The Inspector General advised providers that such unethical practices may expose both the consultants and their clients to legal liability. Questionable practices of any sort should be considered grounds for terminating the services of a consultant, as they could be attributed to the provider and result in: fines, disqualification from participation in Medicare and Medicaid programs, and in some instances, jail time. It should never be assumed that the advice of a business consultant is necessarily in compliance with the law.

We hope that you have found this brief update to be helpful. Should you have any concerns about these issues or we may assist you in any other capacity, please feel free to contact our office.