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Late breaking news on medical-legal developments affecting physicians and health care professionals

Supreme Court to Rule on Theory Underlying False Claims Act Suits: The United States Supreme Court recently granted *certiorari* in the case of *Universal Health Services v. United States ex rel. Escobar*. The case before the court focuses on one theory whistle-blowers and the government use in bringing False Claims Act ("FCA") cases to court – implied certification. It is widely accepted and understood that the FCA makes it illegal to knowingly submit fraudulent claims to the government. Typically, such cases involve billing for services not actually performed. In recent years, however, FCA litigation has expanded under the theory of "implied certification." Implied certification cases involve whistle-blowers who allege providers submitted false claims by failing to follow applicable regulations. Providers sometimes are held liable for not following technical regulations even if the government never explicitly stated that following those regulations was a condition of payment, and even if the provider never explicitly vouched that it had complied with the regulation. Opponents and critics of the implied certification theory believe it is unconscionable to sue organizations under the FCA for compliance issues arising from thousands of pages of state and federal rules and regulations. It is their belief that federal and state agencies, not the courts, should deal with such violations. With lower courts split on the issue, the Supreme Court will weigh in on this issue, which could potentially deal a crucial blow to many pending and future FCA suits.

Medicare Penalizes 758 Hospitals Over Patient Safety Issues: The CMS recently released a report noting that it would be fining 758 hospitals with higher rates of patient safety incidents. The penalties, which were created in 2010 with the passing of the Affordable Care Act, are the toughest sanctions Medicare has taken on hospital safety to date. The report further noted that more than half of these hospitals were also fined last year. In determining which hospitals should be penalized, the CMS assessed the frequency of several kinds of infections, sepsis, hip fractures and other complications. In response to its findings, Medicare will lower all its payments to the penalized hospitals by 1 percent over the course of the federal fiscal year, which Medicare estimates will cost these hospitals $364 million. Still, patient safety advocates believe the fines are not significant enough to alter hospital behavior and that they only examine a small portion of the types of mistakes that take place at hospitals. Medicare has announced, though, that it does plan to assess more types of conditions in future years. Critics of the Medicare penalties, however, believe that they are counterproductive and unfairly levied against hospitals that have made progress in safety but have not caught up to most facilities. Of particular concern to hospital administrators is the fact that the health law unjustifiably requires Medicare to punish a quarter of hospitals each year. In practice, though, only about 1 in 6 hospitals is being penalized due to Congress' exemption of veterans hospitals, children's hospitals and critical access hospitals, which are generally the sole providers in their areas.

New Jersey Legislature Considering Arbitration for Out-of-Network Provider Disputes: The Assembly Financial Institutions and Insurance Committee recently recommended a two-bill package, A4444 and A952, for passage, which seeks to prevent patients from being hit with unexpected charges for out-of-network services. A similar bill, S20, is pending in the Senate. The legislation would establish an arbitration system to decide fee disputes between providers and health insurers. The legislation also provides for peer review of claims by a panel of experts prior to going to arbitration and the creation of a "Healthcare Price Index," to allow the Department of Banking and Insurance, in conjunction with providers and health insurers, to set allowable rates to be charged by out-of-network providers. The Committee Chairman, Assemblyman Craig Coughlin (D-Middlesex) says the proposed legislation is a "fair and balanced compromise." Coughlin maintains arbitration is the preferred method of settling disputes, and the peer review process should lead to many disputes being settled even before they reach arbitration. The bills are backed by consumer groups and the health insurance industry and opposed by the New Jersey Hospital Association and the Medical Society of New Jersey, who claim the peer review and arbitration processes will add to providers' costs and tend to unfairly favor health insurance carriers. In order to be enacted into law, the bills must first be passed by the full Assembly and Senate and then signed by Governor Christie.

For more information on the above items, contact Kern Augustine Conroy & Schoppmann, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.

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