



# Health Law Section Newsletter



## INSIDE:

Editor's Note .....2

To Tweet or Not to Tweet:  
Florida's Government-in-  
the-Sunshine Law and  
Social Networking.....3

False Claims Act  
Amendments Expand  
Liability for Health Care  
Providers and Anti-  
Retaliation Protections for  
Whistleblowers .....4

Breach Notification  
Requirements for  
the Improper Use or  
Disclosure of Unsecured  
Protected Health  
Information .....6

Referral Relationships  
in Florida's Home  
Health Industry: Anti-  
Fraud Legislation  
Creates Confusion and  
Controversy .....8

Practice Note: Arbitration  
Demand Deadlines, Tort  
Claims and Third Parties  
in Arbitration..... 15

## Usual, Customary and Reasonable Charges (UCR) The Battle Continues

by John D. Buchanan, Jr., Esq., Tallahassee, Florida\*

An analysis and commentary. This article traces the depicted issue of usual, reasonable and customary charges (UCR) between non par providers and payors including the use of data from Ingenix to establish reimbursement for UCR by payors to non par providers and two cases in Florida as to UCR.

### Introduction

The past few years, the battle between insurers and providers have been raging over usual, customary and reasonable charges (UCR) for non-par providers. The issue is how are usual, customary and reasonable charges calculated. Hospitals and doctors claim that the charges are reasonable. The insurers claim that the charges are inflated and do not represent what providers actually bill.

### Unilateral Determination of UCR by Insurers Paying Non-Par Providers

There are several issues as far as providers are concerned in that the insurance industry, particularly insurers who reimburse HMOs, are trying to force providers into a network (par providers) at a negotiated rate that may not be acceptable to the provider. The second issue is that if a provider is a non-par provider, the insurers are unilaterally determining a reimbursement rate which these insurers perceive as proper payment for billed charges. In other words, the insurer does not want to pay for actual bill charges by the provider, but a rate of reimbursement that is unilaterally decided by the insurer based on a number of factors.

See "The Battle Continues" page 12

## Will Exempting Small Healthcare Entities from Red Flags Rule Put Them at Greater Risk?

by Ann Marie Gaitan, Esq., Miami, Florida\*

The Federal Trade Commission ("FTC" or "Commission") is set to begin enforcement of the highly anticipated Red Flags Rule ("Rule") on November 1, 2009. The Rule, developed pursuant to the Fair and Accurate Credit Transactions (FACT) Act of 2003, will require "creditor[s]" to create and implement a written Identity Theft Prevention Program. Although the Red Flags Rule went into effect

on January 1, 2008, enforcement has been suspended numerous times, to provide covered entities additional time to develop and implement written Identity Theft Prevention Programs.

On October 20, 2009 the U.S. House of Representatives passed H.R. 3763, a bill that exempts a healthcare practice, among others, with 20 or fewer employees from the *continued, next page*

## RED FLAGS

from previous page

requirements of the FTC's Red Flags Rule.<sup>1</sup> The bill has now passed to the Senate. Although many in the health care industry are heralding the passage of this bill as the first victory in a long battle to exclude physicians from the definition of "creditor" under the Rule, careful thought must be given to the possible "side effects" of such legislation.

One fact often overlooked in the identity theft debate is that although the FTC has been unwavering in its refusal to exempt the health care industry from the Rule, the Commission has recognized that in medical practices where the staff is familiar with everyone who walks through its doors, there is little risk of identity theft. Thus, the FTC has reasoned that for small medical practices the "risk of identity theft may be so low that, as a matter of prosecutorial discretion, Commission staff would be unlikely to recommend bringing a law enforcement action."<sup>2</sup> However, if H.R. 3763 is passed by the Senate this may no longer be the case. For one, this bill

creates an exemption to the Rule that is based on "practice size," rather than one that is "industry-based." As such, the bill reaffirms the FTC's position that physicians fall under the definition of a "creditor" and are subject to the Red Flags Rule - an interpretation highly contended by the American Medical Association ("AMA").

H.R. 3763 may also have the additional unwanted effect of redirecting criminal activity away from the larger organizations, like hospitals and toward the smaller and more vulnerable healthcare practices, like that of the primary care physician. By isolating small healthcare practices, this pending law will not only expose them to increased criminality but will also make small medical practices the subject of tougher regulation in the future, and more costly compliance.

The debate over the Red Flags Rule is not over. Members of the health care industry should expect more legislation and proposed changes over the upcoming months. Nevertheless, one thing is for certain: November 1, 2009 is quickly approaching. And, as of yet, medical practices - of all sizes - must

come into compliance by this date.<sup>3</sup>

*\* Ann Marie Gaitan, Esq., is a partner at Gaitan Morales, PPLC, focusing her legal practice in the areas of healthcare, FTC and FDA compliance related matters. Mrs. Gaitan may be reached via e-mail at [amgaitan@gaitanmorales.com](mailto:amgaitan@gaitanmorales.com).*

### Endnotes:

1 H.R. 3763, as passed, excludes from the term "creditor" a health care practice, an accounting practice and a legal practice "with 20 or fewer employees." The bill also creates an avenue for "any other business" to submit an application to be excluded from the meaning of "creditor" under the rule, at the FTC's discretion. The full text of the bill is available at <http://www.govtrack.us/congress/billtext.xpd?bill=h111-3763>.

2 See The Red Flags Rule: Frequently Asked Questions, at question E-3, available at <http://ftc.gov/bcp/edu/microsites/redflagsrule/faqs.shtml#E>.

3 The AMA has issued a practice management guide for physician which can be viewed at <http://www.ama-assn.org/ama1/pub/upload/mm/368/red-flags-rule-edu.pdf>.

## Editor's Note

by Thomas P. Clark, Esq., Fort Myers, Florida\*

Welcome to the latest edition of the Florida Bar Health Law Section e-newsletter. This edition contains seven articles covering the following topics: (a) Usual, Customary and Reasonable Charges; (b) False Claims Act Amendments; (c) Red Flags Rule; (d) Florida's Government-in-the-Sunshine Law and Social Networking; (e) Referral Relationships in Florida's Home Health Industry; (f) a Practice Note on Arbitration; and (g) HITECH Breach Notification Requirements.

As you may be aware, on June 24, 2009, the Governor approved an act, effective as of July 1, 2009, relating to health care, Chapter 2009-223, 2009 Fla. Laws (the "Act"). This Act (which has been referred to as Senate Bill 1986) contains a number of modifications and amendments to various Florida health care laws. Some of these modifications and amendments involve changes relating to Medicaid fraud, False Claims, licensure requirements, and the Health Care Licensing Procedures Act. The Act also contains an amendment to the Florida Patient Self-Referral Act which excludes referrals to a sleep care provider for sleep related testing.

On behalf of the Health Law Section, I would like to thank the staff at the Florida Bar for their assistance with this edition. I also would like to thank the authors who submitted articles for publication. Without their help and support it would not be possible to continue the newsletter. If you are interested in submitting articles for publication, please submit them to me at [thomas.clark@henlaw.com](mailto:thomas.clark@henlaw.com). I look forward to working with you.

*\* Thomas P. Clark, Esq., is a shareholder with the law firm of Henderson, Franklin, Starnes & Holt, P.A., located at 1715 Monroe Street, Fort Myers, Florida 33902. Mr. Clark is a Member of the Health Law Section and Tax Section of The Florida Bar. Mr. Clark is Board Certified by the Florida Bar in Health Law and Tax Law. Mr. Clark may be reached at (239) 344-1178 or [thomas.clark@henlaw.com](mailto:thomas.clark@henlaw.com)*

# To Tweet or Not to Tweet: Florida's Government-in-the-Sunshine Law and Social Networking

By Nicholas W. Romanello, Esquire, West Palm Beach\*

According to the Florida Department of Community Affairs, Florida has more than seventy five (75) special taxing districts (Districts) whose mission is limited to the administration of hospitals, health facilities or health care. Some of these Districts are significant actors in the health care delivery system while others play smaller roles in their communities. Large or small, these Districts share the common element of being regarded as instrumentalities of local government under Florida law.<sup>1</sup>

To ensure transparency in the public deliberative process, Florida imposes extraordinarily demanding requirements upon Districts. These requirements center upon two primary obligations, maintaining open, public, meetings and the administration of public records.

## **Open Meeting Requirements**

Florida's Government-in-the-Sunshine Law generally requires that "[a]ll meetings ... of any collegial ... special taxing district, at which official acts are to be taken or at which the public business of such body is to be transacted or discussed, shall be open and noticed to the public."<sup>2</sup> The Sunshine Law extends to discussions and deliberations as well as formal actions taken by a public body or commission (Board).<sup>3</sup> Thus, the Sunshine Law applies to any discussion or meeting of "two or more members" of the Board when discussing some matter which will foreseeably come before the Board.<sup>4</sup>

## **Public Records**

Florida's Constitution entitles every person with the right to inspect or copy any public record made or received in connection with the official business of any public body, officer or employee of the state, or persons acting on their behalf, except with respect to records exempted ... or specifically made con-

fidential.<sup>5</sup> In short, Florida's Government-in-the-Sunshine law directs the manner in which Districts administer their business records. The Sunshine Law's rules concerning public records also extends to written communications, electronic mail, and SMS or text messages between Board members.

Any member of a public Board, commission or political subdivision who knowingly violates the Sunshine Law is guilty of a misdemeanor of the second degree.<sup>6</sup> Additionally, the Governor is authorized to suspend any elected or appointed official who is charged with any misdemeanor arising directly out of their official duty.<sup>7</sup>

## **Social Networking Sites**

Social networking websites enable users to create individual profiles, interact with other users in real-time and build virtual networks of friends or constituents. Well known examples of such sites include Facebook, MySpace, Twitter and LinkedIn. The proliferation of social networking sites create new and enhanced opportunities for local governments to meet and communicate with constituents. Many state and local governments have created social networking sites as a way to serve constituents. Hospital or healthcare Districts may view social networking sites as an innovative way in which to provide information and services to their patients. Social networking sites also bring about new challenges relative to Sunshine Law obligations.

The Florida Attorney General has recently weighed in on the issue. Attorney General's Opinion (AGO) 09-19 addresses issues surrounding municipal social networking pages and the implications of this practice under Florida's Government-in-the-Sunshine Law.

## **Concerns with Social Networking Sites**

Social network services focus on building online communities of people who share interests and/or activities, or who are interested in exploring the interests and activities of others. Social network services are web based and provide a variety of ways for users to interact, such as email and instant messaging services. In short, the challenge presented by social networking sites is that some public officials may unintentionally circumvent the Sunshine Law's prohibition against communicating with fellow Board members by way of email, text messages or other evolving means of electronic communication. Additionally, the maintenance of a social networking site by a District creates a new category of public records which are accessible to the public.

## **Attorney General Opinion 09-19**

In AGO 09-19, the Florida Attorney General responded to a question posed by the city of Coral Springs. Specifically, Coral Springs inquired as to their Sunshine Law obligations with respect to a city maintained page on a popular social networking site. In short, the Florida Attorney General opined that the creation and maintenance of a municipal social networking page does implicate Florida's Government-in-the-Sunshine Law subjecting the contents of the page to public disclosure.

Additionally, the Attorney General warned that "while there would not appear to be a prohibition against a board or commission member posting comments on the city's Facebook page, members of the board or commission must not engage in an exchange or discussion of matters that foreseeably will come before the board or commission for official action."

See "To Tweet or Not to Tweet" page 12



# False Claims Act Amendments Expand Liability for Health Care Providers and Anti-Retaliation Protections for Whistleblowers

by Kevin J. Darken, Tampa, Florida\*

The False Claims Act ("FCA"), the primary weapon used by the United States to recover funds lost to health care fraud, was amended by the Fraud Enforcement and Recovery Act of 2009 effective May 20, 2009 (the "Act"). This article summarizes the major changes made to the False Claims Act which expanded both the scope of potential liability of the health care providers and the anti-retaliation protections provided to whistleblowers.

## I. Liability for Knowing Retention of Any Overpayment

The Act now contains language making it an FCA violation to knowingly conceal or knowingly and improperly avoid or decrease an "obligation" to pay or transmit money or property to the Government. 31 U.S.C. § 3729(a)(1)(G). In addition, the definition of "obligation" is expanded greatly to include "the retention of any overpayment." 31 U.S.C. § 3729(b)(3). The Senate report to the Act states that "the violation of the FCA for receiving an overpayment may occur once an overpayment is knowingly and improperly retained, without notice to the Government about the overpayment."

Congressman Howard Berman, the House sponsor of the False Claims Act Amendments, explained that "if a corporation learns after-the-fact that it has been violating a billing rule or a contract requirement in its billing, and it nonetheless fails to comply with a legal obligation to disclose the resulting overpayments, this amendment renders the corporation liable under the Act for all overpayments resulting from the violation of the billing rule or contract requirement, even those not specifically identified or quantified."

## II. Expansion of "Claim" to Include Claims Made to

### Contractors and Grantees

The Act no longer requires the direct presentment of a claim to an officer, employee or agent of the United States. Instead, claims made to contractors, grantees, and other recipients can form the basis for FCA violations "if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded, or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded ...." 31 U.S.C. § 3729(b)(2)(A). Demands for payment as compensation for federal employment and as an income subsidy without use restrictions are excluded from this definition. 31 U.S.C. § 3729(2)(B).

The Senate report specifies that the False Claims Act Amendments "clarifies the position taken by the Committee in 1986 that the FCA reaches all false claims submitted to State administered Medicaid programs."

These amendments were explicitly designed to reverse the District of Columbia Circuit's decision in *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488 (D.C. Cir. 2005) that the FCA limited liability for submitting false claims to claims presented directly to the federal government and the Supreme Court's decision in *Allison Engine Co. v. United States ex rel. Sanders*, 128 S.Ct. 2123 (2008) that liability under the FCA for knowing false statements was limited to false statements made to get false claims paid directly by the federal government.

## III. Materiality Requirement for False Records or Statements

The Act now clearly requires that false records or statements must be material to getting a false or fraudulent claim paid in order to be actionable. However, "material" is broadly defined as meaning to have "a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

## IV. Changes to Anti-Retaliation Provisions of 31 U.S.C. § 3730(h)

*continued, next page*

# LRS

## JOIN THE FLORIDA BAR'S LAWYER REFERRAL SERVICE!

In 2005, The Florida Bar Lawyer Referral Staff made over 125,000 referrals to people seeking legal assistance. Lawyer Referral Service attorneys collected over \$6.8 million in fees from Lawyer Referral Service clients.

### The Florida Bar Lawyer Referral Service:

- Provides statewide advertising
- Provides a toll-free telephone number
- Matches attorneys with prospective clients
- Screens clients by geographical area and legal problem
- Allows the attorney to negotiate fees
- Provides a good source for new clients

### CONTACT THE FLORIDA BAR TODAY FOR MORE INFORMATION.

**CONTACT:** The Florida Bar Lawyer Referral Service, 651 E. Jefferson Street, Tallahassee, FL 32399-2300, phone: 850/561-5810 or 800/342-8060, ext. 5810. Or download an application from The Florida Bar's website at [www.FloridaBar.org](http://www.FloridaBar.org).

## HEALTH CARE

from previous page

The anti-retaliation provisions of 31 U.S.C. § 3730(h) are broadened to protect not only employees, but also contractors and agents. Congressman Berman explained that “this amendment will ensure that Section 3730(h) protects physicians from discrimination by health care providers that employ them as independent contractors, and government subcontractors from discrimination and other retaliation by government prime contractors.”

Section 3730(h)’s protections against being discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment now will be based on “lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor or agent or associated others in furtherance of other efforts to stop one or more [FCA] violations ....” 31 U.S.C. 3730(h). Congressman Berman explained that the purpose of this amendment was to make it clear “that it covers the following types of retaliation that whistleblowers commonly have faced over the course of the last twenty years: (i) retaliation

against not only those who actually file a qui tam action, but also against those who plan to file a qui tam that never gets filed, who blow the whistle internally or externally without the filing of a qui tam action, or who refuse to participate in the wrongdoing; (ii) retaliation against the family members and colleagues of those who have blown the whistle; and (iii) retaliation against contractors and agents of the discriminating party who have been denied relief by some courts because they are not technically ‘employees.’”

Congressman Berman added that “[t]his language is intended to make clear that this subsection protects not only steps taken in furtherance of a potential or actual qui tam action, but also steps taken to remedy the misconduct through methods such as internal reporting to a supervisor or company compliance department and refusals to participate in the misconduct that leads to the false claims, whether or not such steps are clearly in furtherance of a potential or actual qui tam action.” Congressman Berman explained that the language protecting individuals from employment retaliation when “associated others” attempted to stop FCA violations “is intended to deter and penalize indirect retaliation by, for

example, firing a spouse or child of the person who blew the whistle.”

Congressman Berman specified that the amended Section 3730(h) “does not in any way require that a qui tam plaintiff must have refused to engage in the misconduct or tried to stop the fraud internally before he or she may avail themselves of the incentives and protections of the False Claims Act.” The False Claims Act Amendments do not change existing law that “[a]n individual who participates in the fraud, and who for whatever reason does not challenge the misconduct within his or her organization, is still entitled to a relator’s award and the protections of Section 3730(h) unless he or she is otherwise barred by a specific provision in the law.”

## V. Effective Date of Amendments

The FCA amendments generally are effective “on the date of enactment” and apply “to conduct on or after the date of enactment,” which was May 20, 2009. One exception is that the provision reversing the Allison Engine decision is made retroactive to June 7, 2008 and applies to all FCA claims pending on or after that date.

## VI. Conclusion

The False Claims Act Amendments should be of interest to health care lawyers, as well as to employment lawyers and qui tam practitioners. The amendments strengthen the ability of whistleblowers to bring False Claims Act claims and also provide expanded protections for whistleblowers against retaliation.

\* Kevin Darken brings False Claims Act qui tam cases for relators at the Tampa law firm of Cohen, Foster & Romine. He is a former Assistant United States Attorney and Health Care Fraud Coordinator for the United States Attorney’s Office for the Middle District of Florida. Mr. Darken is the author of a health care fraud treatise (Defending and Preventing Health Care Fraud Cases: An Attorney’s Guide: CCH/Aspen, 10th ed. 2008).

### Fastcase provides an 80% discount to Florida Bar Members on our comprehensive 50-state and federal database of primary law - All for only \$195 per year!

Log on to The Florida Bar website at [www.floridabar.org](http://www.floridabar.org) and gain access to Fastcase’s comprehensive online legal library for \$195.

#### FREE to Florida Bar Members:

- U.S. Supreme Court cases
- Federal 5th and 11th Circuit Court Cases
- U.S. Code
- Code of Federal Regulations
- Florida Supreme Court Cases
- Florida Court of Appeals Cases
- The Florida Statutes
- Florida Supreme Court Rules
- State Statutes and Regulations - 50 states

#### Florida Bar Members Can Also Upgrade to the Premium Package For Only \$195 a Year & Receive:

- Supreme & Appellate Cases for all 50 States
- All Federal Circuit Courts
- Federal District Courts
- Federal Bankruptcy Courts
- Board of Tax Appeals
- Tax Court Memorandum Decisions
- U.S. Customs Court

Fastcase is a member benefit of The Florida Bar



# Breach Notification Requirements for the Improper Use or Disclosure of Unsecured Protected Health Information

by William P. Dillon, Esq., Tallahassee, Florida\*

Many health care providers in Florida are already familiar with the funding opportunities relating to the adoption and meaningful use of electronic health records (EHR) as called for in the Health Information Technology and Economic and Clinical Health Act (HITECH).<sup>1</sup> However along with the call to adopt and implement EHRs also comes an increased responsibility and information stewardship obligation relating to the use, disclosure and maintenance of protected health information (PHI). One such obligation comes in the form of the recently issued Interim Final Rule addressing Breach Notification of Unsecured Protected Health Information (the Rule) which goes into effect on September 23, 2009. Health care providers should take appropriate steps to learn the requirements of the Rule and implement appropriate policies and procedures into their respective compliance programs.

In brief, the Rule requires a health care provider to notify an individual in the event that the health care provider, directly or through a business associate, discovers the breach of an individual's unsecured PHI or reasonably believes that there has been such a breach. The Rule also requires a health care provider to report a breach of unsecured PHI to the U.S. Department of Health and Human Services. Such reporting may be on annual or more immediate basis depending on the severity of the breach. The following dis-

cusses in greater detail the obligations of health care providers in the event of a breach of unsecured PHI under both HITECH and Florida's security breach law.

## Breach of Unsecured PHI

Under the Rule a "breach" means the acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.<sup>2</sup> The phrase "compromises the security or privacy of the PHI" means that the breach poses a significant risk of financial, reputational or other harm to the individual.<sup>3</sup> If a use or disclosure of PHI does not contain any of the individual identifiers listed in the HIPAA privacy rule,<sup>4</sup> date of birth and zip code then there is not a breach because the information has been de-identified and would no longer

be considered PHI.

The question of whether a breach "poses a significant risk of financial, reputational or other harm to the individual" would be determined based on a facts and circumstances risk assessment by the health care provider.<sup>5</sup> In commentary to the Rule hypothetical examples, similar to the following, were provided.<sup>6</sup>

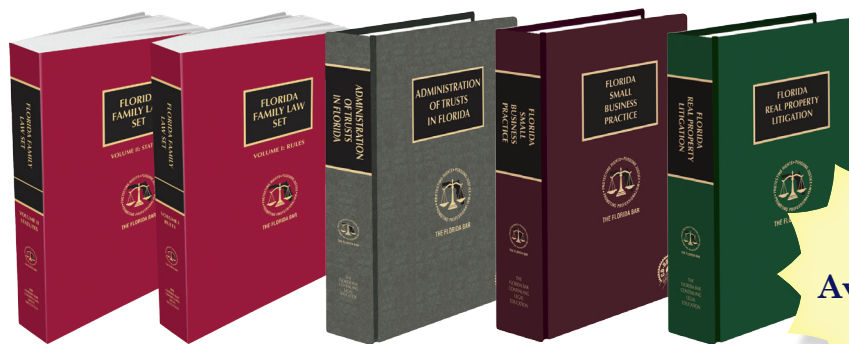
1. A physician office improperly discloses PHI that merely included the name of an individual and the fact that the individual received services from the physician. While such disclosure would be a violation of the HIPAA privacy rule it may not constitute a significant risk of financial or reputational harm to the individual.

*continued, next page*



## Announcement from The Florida Bar

### Are your CLE books out of date?



**Now Available!**

**You will not receive updates unless you have contacted us to confirm your subscriptions.**

**CALL NOW 1-800-533-1637**



## HEALTH INFORMATION

from previous page

2. Alternatively, a physician that improperly discloses PHI which contains information (social security number, patient account number, etc.) that increases the individual's risk of identity theft might be deemed to constitute a significant risk of financial or reputational harm to the individual.

Additionally, any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a health care provider or a business associate would not be considered a breach if the acquisition, access or use was made in good faith and within the scope of authority of the workforce member and does not result in a further improper use or disclosure.<sup>7</sup> Further, an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access protected health information would not be considered a breach if the information was not further used or disclosed in an improper manner. Finally, if a health care provider or business associate had a good faith belief that an unauthorized person to whom a disclosure was made would not reasonably have been able to retain such information the disclosure would not be considered a breach.

Under Florida's version of the security breach law a breach would mean the unlawful and unauthorized acquisition of computerized data that materially compromises the security, confidentiality, or integrity of "personal information."<sup>8</sup> Whereas the Rule encompasses the breach of any PHI, electronic, paper or other medium, the Florida law is limited to the breach of computerized data elements containing an individual's first name, first initial and last name, or any middle name and last name in combination with any one or more of the following unencrypted data elements:

1. Social security number;
2. Driver's license number or Florida Identification Card number;
3. Account number, credit card number, or debit card number, in combination with any required security code, access

code, or password that would permit access to an individual's financial account.<sup>9</sup>

In addition to the above discussion there is one other very important concept that must be understood in order to determine if a breach is subject to the notification requirements of the Rule and/or Florida law. The format or medium of the information that is used or disclosed is essential to determining whether there is a breach for which individual notification is required. Under the Rule notification would only be required for a breach of "unsecured PHI". Unsecured PHI is PHI that has not been rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of an approved technology or methodology.<sup>10</sup>

Essentially, "unsecured PHI" in an electronic format is electronic PHI that has not been properly encrypted. While a discussion of encryption is beyond the scope of this paper there are a number of resources that health care providers may consult to ensure that a proper encryption methodology is being utilized. For example, the National Institute of Standards and Technology (NIST) has published a resource guide for implementing the HIPAA security rule.<sup>11</sup> Included within the resource guide is a discussion of encryption along with references to other resource guides specifically addressing encryption. The NIST guidance would also be applicable in complying with Florida's law. In short if there is a disclosure of electronic PHI or the electronic data elements defined under Florida but such information was properly encrypted there would be no breach under the Rule or Florida law.

Finally and applicable to the Rule only would be the unauthorized access or disclosure of PHI that is not in electronic format, paper, in most instances. Under the Rule, if there was a breach involving unsecured PHI in paper format such breach would be subject to the notification requirements of the Rule. Accordingly, since it is not possible to make a paper record unusable, unreadable or indecipherable, without destroying the record itself a breach involving a paper record would almost always be subject to the notification provisions of the Rule.

## Breach Notification Requirements

Under the Rule a health care provider that discovers a breach of unsecured PHI is required to notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of the breach.<sup>12</sup> A breach is treated as discovered as of the first day on which the breach becomes known to the health care provider or should have reasonably been known to the health care provider. While not addressed as clearly as the Rule, Florida law would also seem to require notification upon learning of a breach of unencrypted computerized data.<sup>13</sup>

Once a health care provider discovers a breach of unsecured PHI both Florida law and the Rule require notification to the individual "without unreasonable delay". Under the Rule the outside time limit for individual notification is 60 calendar days.<sup>14</sup> Under Florida law the outside time limit for notification is 45 days.<sup>15</sup> This creates an interesting and somewhat confusing situation for health care providers in Florida. As you may recall, HIPAA, which now includes this Rule, preempts state law if it would be impossible for a health care provider to comply with both the Rule and Florida law.<sup>16</sup> Clearly this is not the case with regard to which time limit, 45 or 60 days, to utilize as complying with the shorter Florida requirement fits within the more expansive federal requirement. In fact, a state law, which is more stringent than the Rule would not be preempted if it provides individuals with greater protections as the Florida law does.<sup>17</sup> However, the Florida law only applies to computerized data elements specifically identified in the statute and does not include a breach involving information maintained in a paper format.<sup>18</sup> Further complicating the analysis is a provision in the Florida law that would seem to allow a health care provider to default to the notification procedures established by the health care provider's "functional federal regulator".<sup>19</sup>

Accordingly, the surest course of action for health care providers experiencing a breach of unsecured PHI would be for the provider to notify the individual(s) affected by the breach without unreasonable delay but not

See "Health Information" page 20

# Referral Relationships in Florida's Home Health Industry: Anti-Fraud Legislation Creates Confusion and Controversy

by Anne Novick Branan, Esq., Fort Lauderdale, Florida\*

## I. INTRODUCTION

For the second year in a row, the Florida legislature has passed anti-fraud legislation targeting home health agencies (HHAs). In 2008, the legislature amended Florida's home health agency licensure law by prohibiting HHAs from, among other things, having more than one medical director, and from paying any remuneration to discharge planners or referring physicians, their families and staff.

The 2009 amendments to the anti-fraud laws aimed at the home health industry became effective July 1, 2009. The most controversial language of the new law creates a "safe harbor" for business relationships that are permitted by the federal Stark Law,<sup>1</sup> the Federal Anti-Kickback Statute,<sup>2</sup> and their respective regulations. Many believed that this "safe harbor" reversed the marketing and remuneration prohibitions created by the 2008 amendments.

Shortly after the 2009 law became effective, the Florida Agency for Health Care Administration (AHCA), the agency responsible for licensing HHAs, posted on its website revised Frequently Asked Questions (FAQs) that include AHCA's answers to questions on the marketing and remuneration issues affected by the 2009 law. The FAQs provide guidance to the home health industry about the enforcement policies and actions they can anticipate from AHCA. AHCA's guidance appears to be in conflict with the plain text of the 2009 law, and the FAQs have put the industry in a quandary as to what practices will not threaten their licensure status or result in fines. Moreover, the discrepancy between the strict legal analysis of the 2009 amendments and AHCA's enforcement policy has forced Florida health law attorneys into a precarious position when advising home health industry clients about the HHA licensure law.

## II. The 2008 COMBINED SENATE/HOUSE BILL 7083

In 2008, the legislature passed CS/HB 7083, which went into effect on July 1, 2008. The 2008 law expanded the events for which AHCA may impose fines on HHAs and deny, revoke, or suspend such providers' licenses. Under CS/HB 7083, Florida-licensed HHAs could be penalized for conduct and relationships that previously had been considered legal under state and federal law. In fact, many provisions of CS/HB 7083 were even more restrictive than the Medicare conditions of participation for home health agencies, the Federal Anti-kickback Statute, or self-referral prohibitions of the Stark Law.

CS/HB 7083 authorized AHCA to discipline HHAs if they engaged in certain business practices, including if they: (1) have more than one medical director contract in effect at one time unless additional physician-specialist's services are mandated to participate in a federal or state health care program;<sup>3</sup> (2) have a pattern of billing any payer for services not provided, or failing to provide services specified in the plan of care for a patient; (3) give remuneration to a referring physician if the HHAs do not have a compliant medical director contract in effect; or, (4) give cash to a Medicaid or Medicare beneficiary.

Additionally, CS/HB 7083 provided for the discipline of HHAs if they: (1) give remuneration to a referring physician or to a member of a referring physician's office staff or immediate family; (2) pay for staffing services provided by other agencies or health services pools with which HHAs or pools have patient-referral transactions or arrangements; (3) provide services to residents in, or staffing to, an assisted living facility for which the HHAs do not receive fair market value remuneration; and (4) give payment or other benefits

to case managers, discharge planners or staff at a facility from which the HHAs receive referrals.

The 2008 amendments created strict, clear prohibitions against the payment and referral relationships listed above. Marketing and remuneration exceptions in the Federal Anti-Kickback Statute and federal Stark Law, and their respective regulations that allowed certain business practices did not exist in CS/HB 7083. Additionally, AHCA interpreted the prohibitions against remuneration in the most restrictive manner. For example, HHAs were prohibited from providing any remuneration (defined as anything of value) to physicians, their office staff and family members or to discharge planners. AHCA's stated policy was that HHAs were prohibited from providing even low-value logo items like pens, mugs and note pads to these referral sources. Likewise, HHAs could not hire physician family members to work at their agencies. Many spouses and children of physicians lost their jobs with HHAs after CS/HB 7083 became effective.

## III. RELEVANT PROVISIONS OF 2009 SENATE BILL 1986

As Senate Bill 1986 worked its way through the legislature, it appeared that its amendments to the HHA licensure law would ease the marketing and contractual remuneration restrictions established in 2008.

Section 6 of SB 1986 amends (with language changes indicated by underscoring) subsection (6) of section 400.474, Florida Statutes, as follows:

400.474 Administrative penalties.—

(6) The agency may deny, revoke, or suspend the license of a home health agency and shall impose a fine of \$5,000 against a home health agency that ...

*continued, next page*



## ANTI-FRAUD LEGISLATION

from previous page

(e) Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals....

(h) Has more than one medical director contract in effect at one time or more than one medical director contract and one contract with a physician-specialist whose services are mandated for the home health agency in order to qualify to participate in a federal or state health care program at one time.

(i) Gives remuneration to a

physician without a medical director contract being in effect. The contract must:

1. Be in writing and signed by both parties;
2. Provide for remuneration that is at fair market value for an hourly rate, which must be supported by invoices submitted by the medical director describing the work performed, the dates on which that work was performed, and the duration of work; and
3. Be for a term of at least 1 year.

The hourly rate specified in the contract may not be increased during the term of the contract. The home health agency may not execute a subsequent contract with that physician which has an

increased hourly rate and covers any portion of the term that was in the original contract.

(j) Gives remuneration to:

1. A physician, and the home health agency is in violation of paragraph (h) or paragraph (i);
2. A member of the physician's office staff; or
3. An immediate family member of the physician,

if the home health agency has received a patient referral in the preceding 12 months from that physician or physician's office staff.

Nothing in paragraph (e) or paragraph (j) shall be interpreted as applying to or precluding any

THE NOMINATING COMMITTEE OF THE HEALTH LAW SECTION CONSISTING OF THE FOLLOWING MEMBERS IDENTIFIED BELOW MET BY PHONE ON MARCH 22, 2010.

### NOMINATING COMMITTEE MEMBERS:

**Allen R. Grossman, Chair**  
**Michael J. Bittman**  
**Christine C. Whitney**  
**Laurie J. Levin**  
**William P. Dillon**

### THE NOMINATING COMMITTEE NOMINATED THE FOLLOWING PERSONS FOR THE CORRESPONDING OFFICER POSITIONS:

**Chair Elect - Cynthia A. Mikos**  
**Treasurer - Bernabe Icaza**  
**Secretary - Monica Rodriguez**

### THE NOMINATING COMMITTEE NOMINATED THE FOLLOWING PERSONS FOR THE EXPIRING EXECUTIVE COUNCIL POSITIONS:

<b>2011</b>	<b>Mildred Beam (to replace Monica Rodriguez)</b>
	<b>Robert Nicholson (new seat)</b>
<b>2012</b>	<b>Susan Tuite (new seat)</b>
<b>2013</b>	<b>Sandra Greenblatt</b>
	<b>Rodney Johnson</b>
	<b>Jodi Laurence</b>
	<b>Ed Tellechea</b>
	<b>Grant Dearborn (new seat)</b>
	<b>Tom Clark (new seat)</b>

## ANTI-FRAUD LEGISLATION

from previous page

discount, compensation, waiver of payment, or payment practice permitted by 42 U.S.C. s. 1320a7(b) [Federal Anti-kickback Statute] or regulations adopted thereunder, including 42 C.F.R. s. 1001.952, [safe harbor regulations] or 42 U.S.C. s. 1395nn [the Stark Law] or regulations adopted thereunder. *Emphasis added.*

Armed with the plain language of SB 1986, many lawyers and health care industry professionals interpreted this new exception (the “Federal Law Exception”) to eliminate the remuneration prohibitions created in 2008 under CS/HB 7083, so long as those remuneration relationships comply with Stark Law, the Anti-Kickback Statute, or the safe harbor regulations. To understand the impact of the Federal Law Exception, attorneys must be well-acquainted with the language and interpretations of, and government enforcement policies related to, those federal laws, which limit relationships between HHAs and their referrals sources. However, because a thorough discussion of the Stark Law, the Anti-Kickback Statute, and the safe harbor regulations is beyond the scope of this article, the following subsection provides merely a brief overview of the relevant provisions of those laws.

### IV. FEDERAL STARK LAW AND ANTI-KICKBACK STATUTE

#### A. Federal Anti-Kickback Statute

The federal Anti-Kickback Statute makes it a crime for any person to solicit, receive, offer or pay any remuneration in return for referring, arranging for or recommending the referral of, an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, by a federal health care program. The federal Anti-Kickback Statute also makes it a crime for any person to solicit, receive, offer or pay any remuneration to induce a person to purchase, lease, order or arrange for or recommend purchasing or leasing any good, facility or service for which payment may be made, in whole or in part, under a federal health

care program. The Office of the Inspector General of the Department of Health and Human Services has published regulations, found at 42 C.F.R. § 1001.952, that define relationships that are immune from administrative sanctions and criminal prosecution under the federal Anti-kickback Statute. These are commonly referred to as the “safe harbors.”

#### B. The Federal Stark Law

The federal statute governing physician self-referrals, commonly known as the Stark Law, states that if a physician has a financial relationship with an entity, then the physician may not make a referral to the entity for the furnishing of certain designated health services for which payment otherwise may be made by the Medicare or Medicaid programs. Moreover, the entity may not present or cause to be presented a claim or bill to the Medicare or Medicaid programs,<sup>4</sup> or to any other individual, third-party payor, or other entity for the designated health services performed pursuant to the prohibited referral. There are numerous exceptions in the Stark Law and implementing regulations for specific financial relationships, such as leases and services agreements.<sup>5</sup>

“Financial relationship” under the Stark Law includes any direct or indirect compensation arrangement between the physician and the entity. The Stark Law defines “remuneration” to include any discount, forgiveness of debt, or other benefit made directly or indirectly, overtly or covertly, in cash or in kind. “Designated health services” include, among others, home health services.

### V. AHCA FREQUENTLY ASKED QUESTIONS

For at least the last two years, AHCA has been under pressure from the general public and the legislature to curb the perceived fraud in Florida’s home health industry.<sup>6</sup> The 2009 amendments to the HHA licensure statute created a challenge for AHCA to set enforcement policy for its surveyors, since the amendments eliminated clear-cut standards by which AHCA surveyors could be expected to apply the complex nuances of the Stark Law, the Anti-Kickback Statute, or the safe harbor regulations referred to in the Federal Exception.

On July 31, 2009, the AHCA re-

sponded to the changes in the law by issuing the FAQs regarding marketing and remuneration issues affected by the 2009 amendments. AHCA notes in the FAQs that the FAQs and answers are not “an interpretation of the law nor are they statements of AHCA policy.” AHCA further recognizes that the state and federal laws that govern health facilities and fraud are complex and suggests that HHAs “consult with a health care attorney for their particular issue.”

Many of AHCA’s answers to the questions posed in the FAQs reflect AHCA’s guidance after the 2008 amendments and refer readers to AHCA’s answers to question #14.2.12 which addresses the effect of 2009 amendments. In the FAQs, AHCA discusses the Federal Exception and states:

This 2009 amendment references the Federal Anti-Kickback Law and the Stark Law and their regulations. The 2009 amendment did not modify any other paragraph under Section 400.474(6) and thus the 2009 amendment is limited to paragraphs (e) and (j). The prohibitions under paragraph (i), i.e., giving remuneration to physicians, are unaffected by the 2009 amendment.

As for Subsections 400.474(6)(e) and (j), if a home health agency can establish that a federal safe harbor applies to its situation, the giving of some forms of remuneration “may” be permitted by the 2009 amendment. However, remuneration still does not include meals, food, beverages, gifts, event tickets, flowers, and other similar items. A “safe harbor” is a provision in the federal regulations that permits certain arrangements and would serve as a defense in enforcement actions. These two federal laws are complex. A home health agency should determine (a) whether one of these two federal laws applies to it, (b) whether a safe harbor applies to it, and (c) whether it has satisfied the burdens of satisfying the safe harbor. The burden of establishing that a safe harbor exists rests upon the home health agency. Because of the

*continued, next page*

complexity of these two federal laws, home health agencies are encouraged to consult with a health care attorney.

There has been much discussion and controversy about whether the Federal Exception as written was intended to be limited in its application to Section 400.474(6)(e) Fla. Stat. and Section 400.474(6)(j) Fla. Stat. Many attorneys have read the language to exclude Subsection (6)(i) from the application of the Federal Exception, loosening the general prohibition against remuneration provided to a physician. This issue continues to be unresolved, leaving questions as to how the Federal Exception will affect HHA licensure.

Of particular interest to health law attorneys is the fact that the FAQs say that if a HHA can establish that a federal safe harbor applies to a particular situation, the giving of some forms of remuneration "may" be permitted by the 2009 amendment. AHCA then lays out a three-pronged standard that HHAs should use to establish that a safe harbor applies. While at first glance, the three-pronged standard appears to provide reasonably clear guidance for HHAs on how to deal with the 2009 amendment, the answer to FAQ 14.2.12 creates confusion by adding that "remuneration still does not include meals, food, beverages, gifts, event tickets, flowers, and other similar items." There are federal safe harbors and Stark Law exceptions that will allow these forms of remuneration under certain circumstances. Moreover, it is unclear how or at what point in a survey or appeal process the advice from legal counsel or the proof that a business practice satisfies a federal safe harbor would serve as a defense to enforcement actions.

## VI. WHERE DO WE GO FROM HERE?

Florida health law attorneys are now presented with a dilemma when asked to answer clients' basic questions regarding how the current HHA licensure law will affect their business. Health lawyers are challenged to address common questions with reference to both the law as it was written by the Florida legislature and AHCA's proposed enforcement guidance as presented in its FAQs. One solution for

attorneys attempting to advise HHA clients may be to draft advisory opinions, addressing the law as it is written. But clients must be aware that providing a favorable attorney-drafted advisory opinion to AHCA surveyors will not necessarily preclude the possibility of having to defend against administrative penalties in the future. Those battles can be costly and time-consuming. Additionally, HHAs should be made aware that providing such an opinion to a surveyor may waive attorney-client and work product privileges associated with such a legal advice.

We expect that the confusion created by the Federal Exception will be addressed by the 2010 Florida legislature. It is unlikely that its resolution will be less restrictive to HHAs. AHCA will probably push for enforcement under the much more black-and-white standards of the 2008 laws. Expecting surveyors to assess HHAs in light of the complex federal laws referred to in the Federal Exception was likely an unintended consequence of the legislature's passing such a provision.

In light of AHCA's FAQ and the unclear language of the 2009 amendments, the law licensing HHAs in Florida has become murky and complex, requiring attorneys to give advice without guarantees that their HHA clients will not be sanctioned. The risk of suspension or revocation of a HHA's license is real, as AHCA has been given the authority to take such action if the remuneration prohibitions are violated. Without a license, an HHA will be out of

business. In today's enforcement climate and with the clear direction to AHCA from the legislature to curb fraud, it is unlikely that AHCA will be lenient in reinstating licenses that are suspended because of improper remuneration to referral sources. Thus, Florida health law attorneys must proceed carefully when advising HHA clients with regard to the HHA licensure laws.

*\* Anne Novick Branan, Esq., practices Health Care Law with the Law Firm of Broad and Cassel in Fort Lauderdale, Florida. The author wishes to acknowledge the efforts of Barbara Viota-Sawisch, Esq. and Tara Ravichandran, Esq. for their assistance in the completion of this article.*

### Endnotes:

- 1 42 U.S.C. § 1395nn (2009).
- 2 42 U.S.C. § 1370a-7b(b) (2009).
- 3 In such cases, a home health agency may have no more than one medical director contract and one contract with a physician-specialist.
- 4 42 U.S.C. § 1395nn.
- 5 See 42.C.F.R. § 411, Subpart J (2009).
- 6 As an additional anti-fraud measure, SB 1986 also imposed limits on AHCA's authorization to issue new HHA licenses and to approve change of ownership applications in counties with certain population/HHA ratios. Broward and Dade counties are most affected by these limits which are in effect until July 1, 2010 unless extended by the legislature in its next session.



**Florida Bar members save with FedEx.**



Florida Bar members can now enjoy savings of up to 26% off select FedEx® services.\* Enroll today and start enjoying your special savings on FedEx shipping to help put your business a few steps ahead of the competition.

**1-800-MEMBERS**  
(1-800-636-2377) 8 a.m.-6 p.m. EST



\*Shipping discounts are exclusive of any FedEx surcharges, premiums or special handling fees and are not available to package consolidators. Eligibility for discounts subject to FedEx credit approval. FedEx First Overnight®, FedEx SameDay®, FedEx® International Next Flight, FedEx International First®, FedEx International Priority Direct Distribution®, FedEx® 10kg Box, FedEx® 25kg Box and FedEx International Mail Service® not included. Eligible services subject to change. Basic discounts on FedEx Express® are 15%-21%. An additional 5% discount is available for eligible FedEx Express® shipments when you ship online at fedex.com. For details on the FedEx Money-Back Guarantee, see Service Info at fedex.com. Discounts are subject to change. The FedEx Ground money-back guarantee applies to deliveries within the U.S. For details see the FedEx Ground Tariff. ©2009 FedEx.



## TO TWEET OR NOT TO TWEET

from page 3

Engaging in an exchange of ideas or discussion on such matters is a not advised. Comments made on the site by one Board member in reaction to the letters, emails or personal postings of another Board member may be broadly construed as such an exchange or discussion and thus constitute a violation of the Sunshine Law.

Similar concerns regarding record retention and Sunshine Law violations would abound in the undertaking of a personal website by a Commissioner if information on the site fell within the definition of "public records" as defined in Florida Statutes and case law.

### Conclusions and Recommendations

Best practices direct that any proposed social networking site developed by a public hospital or healthcare system not be interactive and be limited to providing system constituents with information concerning services, benefits and programs. Social networking sites or websites for individual Board members is also discouraged. If individual Board members wish to have their own social networking site and/or website, they should be used for informational purposes only or to solicit constituent opinions. However care should be

taken to avoid posting position statements held by Board members on issues that may foreseeably come before the Board. It should also be noted that even on personal websites, retention schedules for public records must be followed.

The exchange of opinions and discussions between Board members on material that may foreseeably come before the Board via email (as well as via telephone or written memoranda) is to be avoided. Such conduct could, of course, violate the Sunshine law carrying significant penalties and consequences. In short, the evolution of technology creates new opportunity to communicate and provides services to patients. The most recent example of this technological evolution is the proliferation of social networking sites. Attorneys advising public hospitals or healthcare systems should evaluate the implementation of social networking sites by, in part, recognizing the impact of Florida's Government-in-the-Sunshine Laws on such sites.

*\* Nicholas W. Romanello, Esquire is the Legal Counsel to the Health Care District of Palm Beach County which provides health coverage for low-income residents, a nationally acclaimed trauma system, clinics with a dedicated nurse in more than 170 public schools, a pharmacy network, a long-term skilled nursing and a rehabilitation center and acute care hospital services at Lakeside*

*Medical Center, the county's only public hospital. The interpretations of law and opinions contained in this note are personal to the author and not those of the Health Care District of Palm Beach County, its Board of Commissioners or executive management and staff. He can be reached at 561.659.1270 and nromanel@hcdpbc.org.*

### Endnotes:

- 1 See, *Eldred v. North Broward Hospital District*, 498 So. 2d 911 (Fla. 1986) and *Lee v. South Broward Hospital District*, 473 So. 2d 1322 (Fla. 4th DCA 1985).
- 2 Art. I, Sec 24(b), Fla. Const.
- 3 While this note directly addresses issues with public boards it is equally applicable to the entire governance structure of a special taxing district including committees and support boards. *Town of Palm Beach v. Gradison*, 296 So. 2d 473 (Fla. 1974); *Accord, Spillis Candela & Partners, Inc. v. Centrust Savings Bank*, 535 So. 2d 694 (Fla. 3d DCA 1988). "[T]he Sunshine Law equally binds all members of governmental bodies, be they advisory committee members or elected officials."
- 4 *Hough v. Stembridge*, 278 So. 2d 288 (Fla. 3d DCA 1973). See also, *City of Miami Beach v. Berns*, 245 So. 2d 38 (Fla. 1971); *Board of Public Instruction of Broward County v. Doran*, 224 So. 2d 693 (Fla.1969); and *Wolfson v. State*, 344 So. 2d 611 (Fla. 2d DCA 1977).
- 5 Art. I, Sec 24 (a), Fla. Const.
- 6 Section 286.011(3)(b), Florida Statutes (2009)
- 7 Section 112.52(1), Florida Statutes (2009).

## THE BATTLE CONTINUES

from page 1

The insurers' reimbursement rate is flawed in that the reimbursement rate that the insurers attempt to provide have a number of weaknesses. An insurer may use data from several large par providers under the guise that these rates are usual, customary and reasonable. However, the large par providers may have reduced some charges in certain areas, such as a particular service of a hospital, and yet charge a higher negotiated rate for other services, such as open heart surgery, because it is the only service in town. This trade off because of the buying power of the large hospital or large organization does not truly

represent what the usual, customary and reasonable charges will be in a geographic area.

Non-par provider's charges, including doctors and hospitals, should not be paid under a faulty system of what the insurers contend should be billed charges, not actual charges.

This system for determining reimbursement by the insurer are claimed to be confidential. On the other side, hospital's charges are transparent in that probably a chargemaster has been filed with the Agency for Healthcare Administration and under Medicare, a hospital provider cannot differentiate on its charges among various payors. While Medicare and Medicaid

determine what a provider will receive under each of those programs, and that is a contractual relationship, the provider only has the choice of either accepting that reimbursement or not participating in the program. The provider who is non-par has no choice and can not inflate those charges to a particular insurer because that would be a violation of both federal and state laws under the Medicare and Medicaid programs. Certainly a provider is not required to receive as reimbursement where another provider has agreed as a par provider to provide services at a different rate and there may be a number of reasons for doing so, but it's still a freedom of choice for a non-par provider.

continued, next page

## THE BATTLE CONTINUES

from previous page

Both hospital and physician providers will tell you that reimbursement at 120 percent of Medicare rate is unrealistic to cover all costs. Usually Medicare and Medicaid do not actually cover all the costs of the provider, and the provider must rely upon private payors to subsidize the losses that may be due to Medicare and Medicaid reimbursement. This cost shifting, while benefiting governmental programs, is in a sense a hidden tax against the private payors who help subsidize the Medicare and Medicaid program for higher charges to private pay patients.

### Payment Base Determination by Insurers by Use of the Data Supplied by Ingenix.

Ingenix is a 100 percent subsidiary owned by United Health Care that was created some years ago to provide a data base on what insurers perceive as being a valid basis to justify the insurers paying less than actual charges billed by a provider, and to justify a reimbursement that the insurers claim was a valid basis and what billed charges should be. This practice of using this faulty data to reimburse providers has been in use for a number of years.

In addition, the insured under the insurance plan who may have had a co-pay and also a percentage of charges by a provider would pay the calculated amount based on the actual charges submitted by the provider when in fact the insurer would have reimbursed the provider at the lesser rate as determined by the insurer presumably based on the Ingenix data, which resulted in the insured being short-changed by the insurer.

On February 13, 2008, the Attorney General of New York State, Andrew M. Cuomo, announced a sweeping investigation into whether the health insurance companies have systematically forced patients to pay more than they should when using doctors and hospitals outside their insurer's networks. In this announcement, Mr. Cuomo stated that he intended to sue UnitedHealth Group, Inc. See, In *the matter of UnitedHealth Group, Inc.*

On January 13, 2009, Mr. Cuomo announced that he reached a Settlement Agreement with UnitedHealth Group, Inc. In his investigation, Attorney General Cuomo found that large health insurers in New York and around the country, including UnitedHealth Group, Inc., Aetna, Signa, and Well Point, use Ingenix schedules. The Ingenix schedules were used in determining reimbursement rates for out of network care. Knowledge that Ingenix was a wholly owned subsidiary of United Health, that Ingenix had a conflict of interest in creating the schedules used as a basis for reimbursement, and that health insurers have incentive to manipulate the data they submitted to Ingenix so as to suppress reimbursement rates, and they found that the Ingenix data bases are a black box as to what reimbursement rates to expect for their out of network care. Under this Settlement Agreement, New York found that the insurer understated the usual and customary rate to reduce the amount of reimbursement to consumers. The Attorney General, by agreement with the defendants, established that an independent third party free of conflicts of interest should set rates. As a result, a new corporation was to be created at a qualified university to establish and operate an independent data base. United would contribute \$50 million to establish this non-profit corporation.

Aetna, under the Settlement Agreement with the Attorney General, State of New York, contributed \$20 million for the benefit of the non-profit corporation.

In a suit filed in the United States District Court for California against Well Point, Inc.<sup>1</sup>, the American Medical Association, California Medical Association, a medical association in Georgia, Connecticut, North Carolina, and individual physicians alleged that Well Point had contributed to provider charge data to Ingenix and alleged that there was a defective and conflict ridden Ingenix data base that failed to comply with the definition of usual, customary and reasonable charges in Well Point's insurance contracts. They claimed that Well Point used this as a tool to deny, delay and impede lawful reimbursement to non-parties. The further allegations are that Well Point's Executive Vice President and CEO of commercial business acknowledged a

conflict of interest in the Ingenix data base in a press release and that the insurer pay \$10 million in settlement with the New York Attorney General. It was further alleged that Well Point routinely and systematically under paid non-pars who submitted claims for reimbursement for out of network services.

The Ingenix probe by the New York Attorney General has fueled a class action suit. *Watchell v. Health Net Inc.*,<sup>2</sup> United States District Court, in an opinion issued by Judge Hochberg dated August 8, 2008, civil number 01-4183, found the following when Ingenix was used by Health Net:

The major flaws in the collection used as a proxy for UCR and that Health Net out of network charges would be calculated based on the UCR charge for a particular service. Health Net determined the UCR charge for a given procedure by consulting two Ingenix data bases. The data bases were PACS and MDR/Medicode data base. The Court had questioned whether these were reasonable charges for a particular service for the geographical area where the service was performed. The Court reasoned that to assess a reasonable charge for a particular medical service, it was essential to know the actual charges billed by similar providers for reasonably similar services in a relatively geographic area. The data base would need to contain information on those factors would affect the cost of services such as significant differences in provider qualifications, significant difference in type of medical services provided, and significant difference in medical market areas. With this information, a data base analysis then could determine what charges are reasonable and which are too high.

The Court found that there were two serious flaws in Ingenix data collection methods. Once related to Ingenix data sources, the other related to the number of data points collected for each medical procedure. The data base was compiled from data submitted by several insurers pursuant to a purely voluntary data contribution program. Under this program, some, but not all of only those health insurers that are Ingenix clients submitted information on a purely voluntary basis about the amounts that have to be billed by an

*continued, next page*

## THE BATTLE CONTINUES

*from previous page*

undisclosed number of unidentified health providers for a specific CPT code service. The Ingenix data base included bills of unspecified number of medical providers, who within a specified period of time have to bill only those health insurers that were not only Ingenix clients, but also Ingenix clients that elected to participate in Ingenix involuntary data contribution program.

This data collection is considered by statisticians to be a convenient sample and is easy to collect, but is a haphazard way to do it. They are chosen on the basis of expediency, cost efficiency, or other reasons, not directly concerned with scientific sampling parameters. As a result, convenient samples are considered the most suspect type of sample. A convenient sample is not necessarily invalid but must be subject to further testing to determine whether the data collected is in fact representative of what an insurer is trying to estimate.

Ingenix did not test the voluntary submitted data to see if the data constituted an active representation sample of charges for a particular procedure in a particular geographic area. A collection methodology provided no reassurance that the raw data collected in the representative of the actual charge is billed for any given procedure. Companies that submitted data received a discount based on the amount of usable data submitted. This encouraged insurers to remove the high charges before submitting their data in order to ensure that a lot of it was not going to be knocked out during the data scrubbing process. Because other insurance companies who use the data base were permitted to choose what data to submit, there is a built-in incentive to submit low cost data that will produce a lower UCR data base, and that the submitting company will use to calculate a lower UCR for its own reimbursements to its insured. The data base relies upon just four pieces of data for each submitted charge: date of service, five-digit current procedure terminology code (CPT code), the address where the procedure was performed, and the amount of the provider's billed charge. Ingenix relied upon these four data points to facilitate comparison among

similar procedures in geographical zones. These data points represented the total of the information that allowed an insured to compare similar situated procedures.

These four data points have used several facts that are critical to the core concepts of UCR. The four data points did not identify the provider's licensure or qualification, the patient's age or health status, the type of facility where the procedure was performed, the data base did not take into account whether a particular procedure was performed by a highly skilled board certified specialist or a general practitioner, or a para-professional, or a nurse. These factors had to be fundamental to a comparison of charges. A procedure performed by a highly skilled physician is likely to be more expensive than one performed by a physician's assistant or nurse practitioner, but the physician's higher charge may nevertheless be the most valid to compare if an insured was treated by a physician of a comparable skill and experience. Excluding every possible type of provider in CPT code service, a totally average bill from a skilled physician would be higher than the UCR yielded by the data base. These excluded data points may be the most important factor in determining reasonable and customary costs. The data base improperly assumed these factors were relevant in determining usual and customary charge for a particular procedure. An accurate data base would control these additional factors.

Ingenix's failure to control these factors meant that the data base is not actually comparing similarly situated procedures which purportedly yields a usual and customary rate for the procedure.

The next problem in collecting data also undermines the Court's concept of UCR is the data is scrubbed to remove certain charges. The process is not per se improper to ensure an accurate data base, it is necessary to review a data base and remove erroneous or incorrectly reported charges. Erroneous outlier values that are either too high or too low will skew the data and can be removed if done by a consistently fair and reliable method. The method which the data base determines which values or outliers.

The data uses a mean to median test to scrub the data. The data base eliminates all bills for a given CPT code if the mean to median ratio within the CPT code is above 2.5 for surgical CPT codes and 1.5 for medical CPT codes. The higher the fees contained in the data set, the more likely the mean to median ratio will remove these fees. This method of scrubbing would bias the resulting distribution downwards. The data base data scrubbing method is also considered by statisticians to be one of convenience. The data base did not review outlier values to determine whether high values are accurate. Rather, the data base simply removed all high fees without any evidence that those values represented data errors. The high charge resulting from a skilled surgeon performing a difficult operation at an excellent medical facility may appear as a statistical outlier when compared to all charges for procedures in the same CPT code without regard to the identity of the provider, the procedure difficulty, or location of service. Under Ingenix method, the outlier data would not be reviewed individually to consider whether it was valid. It would simply be thrown out as too high, which would skew the data downward. This method, compounded by the fact that many of the data providers themselves pre-scrub the data they submitted to Ingenix. Pre-scrubbing provided an incentive for a downward bias.

Ingenix then applies the scrubbing process to groups of CPT codes in a way that further skews UCR rates downward. Each individual CPT code represents a different procedure and as a result, the mean charge for each individual CPT code may differ. Ingenix attempts to account for the differences between CPT codes by giving a relative value for each CPT code. The CPT code values are standardized and combined into groups. The group values are then subject to formulas to eliminate outlier data at the high and low end. Standardizing charges in this way without also taking into account the standard deviation within each CPT code with improperly skew the UCR rate downward because the method fails to account for differing charges within each CPT code. Charges within some CPT codes for routine procedures may be tightly grouped, other CPT codes

*continued, next page*



## THE BATTLE CONTINUES

from previous page

may have a wide distribution reflecting differences in the provider's skill, patient and condition. The methodology used to create this data base rests on the assumption that the distribution of charges as to all CPT codes and CPT code range is the same. This erroneous assumption is that high charges which are valid, usual and customary, are rejected as unreliable outliers, and are eliminated from the data and are thereby skewing downward the upper percentile by using the final reported data.

Data that survives the scrubbing process is then compiled by CPT code. If a CPT code has nine or more charges, those charges are reported as actual data. Actual data is reported for just 10 percent of all CPT codes.

Ingenix derives data for the remaining 90 percent of CPT codes that have fewer than nine charges. This method for deriving data for the CPT codes involving combining CPT codes and standardize the values so the values can be compared across CPT codes. Ingenix groups together the CPT codes into a bodily system. Ingenix groups numerous CPT system codes together as upper digestive system. This group of codes contains relatively simple procedures and extremely complex procedures. To standardize these disparity charges, Ingenix uses relative values provided by a company called Relative Value Studies, Inc.

This process is similar to that use of scrubbing stage that using different relative values. This process suffers from the same fundamental flaws the scrubbing process that assumes that each CPT code has the same distribution of value. Finding that any standardized method must account for differences in both relative values and standard deviations between CPT codes, Ingenix's failure to account for standard deviation when it derives data means almost any charge above the mean in the less common CPT codes with the higher relative standard deviation can appear to be unusually high, even when it is in fact a usual and customary fee. Because the data base fails to account for the fact that some CPT codes have a wider

distribution of charges than others, the derived percentiles understate the true upper percentile values for these CPT codes. For the insured, the end result is that Health Net reimbursed insureds based on an artificially low rate used to reflect UCR.

### Litigation in Florida on Usual, Customary and Reasonable Charges

The real challenge in Florida has come from reimbursement to emergency rooms at hospitals. Under 641.513(5), F.S., there have been two dramatic suits. The Florida Legislature under 641.513(5), F.S., provides for reimbursement for services by a provider who does not have a contract with a health maintenance organization shall be the lesser of (a) the provider's charges, (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

The original case was brought by Adventist Health Systems Sunbelt against Blue Cross/Blue Shield of Florida and Health Options.<sup>3</sup> The case was filed in 2004. There was a partial summary judgment granted, but the Defense was that there was no private cause of action under 641.513(5), F.S. This case went all the way to the Florida Supreme Court, which determined that there was a private cause of action and the case was remanded back to Circuit Court. The Complaint by Adventist was multi count in that there was a declaratory action as well as a claim for damages and other claims. As of the date of this writing, there has been no final action by the Circuit Court in Orange County, even though there has been a partial determination that provider charges meant provider charges by the Circuit Judge.

In a companion case filed in Baker County, Florida, by Ed Fraser Hospital,<sup>4</sup> a final judgment was entered by the Court. In this case, the which, that the Court found that the provider's charge meant the amount billed by the provider. The Court also found, however, that the usual and customary provider charges for similar services in the community where the services were provided was a question of fact. In deciding this

question, the Court stated that different factors were to be considered but not limited to the amounts billed and the amounts received by the provider for payment of similar services. The Court also stated that the question of community was a question of fact not limited to the type of provider payor patient. The Court went on to state that question under clause (b) of 641.513(5), F.S., was a matter to be determined by the Court.

This case was appealed to the First District court of Appeal. Oral argument was held on January 20, 2009, and a decision is awaited by the Hospital that appealed the decision to the First District Court of Appeal as to clause (b) of 641.513(5), F.S. In the Ed Fraser case, the Florida Hospital Association appeared as amicus on the side of the hospital.

In reviewing the statute, it seems a rather simple analysis of what the legislature did is that a provider bills charges for its emergency room services if it's a non-par provider. If there is a dispute, then under clause (b) of 641.513(5), F.S., the Court would have to intervene and make a determination based on the terminology "provider charges," and not a blend of billed charges received by the provider. Under clause (c) of 641.513(5), F.S., if the parties got tired of litigating and decided that the best way to resolve the problem would be to agree on an amount and that the provider would be paid in 60 days.

\* **John D. Buchanan, Jr., Esq., Tallahassee, FL**  
*Henry, Buchanan, Hudson, Suber & Carter*

### EndNotes:

1 *AMA v. Well Point*, CV 09-2039, U.S. Dist. Ct. for Calif.

2 *Wachel v. Health Net Inc.*, U.S. Dist. Ct. N.J. *Case No. 01-4183*, opinion August 8, 2008. See also, *McCoy v. Health Net Inc.* 569 F.Supp. 2nd 448 (D.N.J. 2008).

3 *Adventist Health System Sunbelt v. Blue Cross/Blue Shield of Fla. and Health Options*, Circ. Ct. 9 Judicial Cir. *Case No. 04-CA-3122*.

4 *Ed Fraser Memorial Hospital*, Cir. Ct. *Case 02-2006-CA 0060*, 0061. 1st DCA, *Case No. 1008-67*, oral argument 1/20/09 - no opinion.

# PRACTICE NOTE: ARBITRATION DEMAND DEADLINES, TORT CLAIMS AND THIRD PARTIES IN ARBITRATION

by Harold E. Kaplan, Esq., Coral Springs, Florida\*

When representing a client who is in dispute with a managed care provider, hospital, physician group or others, early on, counsel should carefully scrutinize the pertinent agreement to ascertain, among other things, if there is an arbitration provision and whether or not it encompasses the instant dispute. Counsel should not gloss over the arbitration provision since there are frequently contractual deadlines to make a demand for arbitration, and the arbitration provision may describe or define other aspects of the arbitration process, such as which claims are not subject to arbitration.

There are a number of factual scenarios which arise in the arbitration context and this article will focus on several such scenarios. The author seeks to alert counsel to what is becoming a more prevalent circumstance: demands for arbitration (or failure to bring an arbitration) and related jurisdictional issues, waiver issues, and whether or not a third party can avail itself of the arbitration process.

Failure to comply with the arbitration provision's deadlines can end the proceeding. On the other side, when representing a party being sued in arbitration, counsel should consider whether the plaintiff brought a timely demand for arbitration, whether the plaintiff acted in some manner inconsistent with an arbitration demand, or whether the dispute is subject to arbitration. Strategic concerns may arise as well. Sometimes, the plaintiff may intend to avoid arbitration by filing an action in state court, and the inadvertent or mistaken action of the defendant who acquiesces to the court action may result in a waiver of the defendant's right to arbitrate the action or dispute.

The Arbitration Provision Is A Contractual Agreement. Florida law makes clear that whether a dispute is subject to arbitration is a matter of contract interpretation. In *Seifert v. U.S. Home*

*Corp.*, the Florida Supreme Court stated "arbitration provisions are contractual in nature, construction of such provisions and the contracts in which they appear remains a matter of contract interpretation."<sup>1</sup> There are three (3) elements to address in all arbitrations: (1) whether a valid written agreement to arbitrate exists; (2) whether an arbitrable issue exists; and (3) whether the right to arbitration was waived.<sup>2</sup> Although *Seifert* was a wrongful death tort action against a builder, it is the seminal decision for the underpinnings of arbitration in Florida.

Timeliness Of The Arbitration Demand. The Florida courts have followed *Seifert*. For example, in *Abel Homes at Naranja Villas, LLC v. Anselmo Hernandez and Juaquin Llovera*, the Court stated that "[w]here contractual provisions are clear and unambiguous; the court must give those terms their plain and ordinary meaning."<sup>3</sup>

*Abel Homes* is a good case to illustrate how the drafting party can forget (or was it an overplayed strategy?) to invoke the arbitration provision. It involved two identical real estate purchase agreements which contained a provision which required the purchasers to give the developer twenty (20) days notice of any claims, upon which the developer had to elect to have the matter heard in arbitration. It was undisputed that the purchasers gave the required notice and that the developer failed to elect arbitration within the time provided in the arbitration clause. Here, the Court undertook a de novo review of the contractual provision and concluded that the developer had waived its right to arbitration by failing to timely serve a demand for arbitration within the twenty (20) day time limit specified in the purchase agreement's arbitration provision. The result was that the case could be heard in state court, an outcome which the developer had fought against.

Many other decisions have ruled that the complaining party failed to satisfy the timeliness requirement.<sup>4</sup> The message is clear: If you represent a party who is subject to an arbitration provision, don't miss the deadline to make a demand for arbitration or perhaps use the lack of timeliness to object to arbitration.

In Florida, there is a plethora of reported decisions which hold that the issue of timeliness is a question for the arbitrator and that timeliness is a condition precedent. For example, see *Thierry Albert Thenet v. Ken Jenne*, which involved a terminated sheriff's deputy who filed a request for an arbitration under the applicable collective bargaining agreement and further sought a judicial order to mandate arbitration.<sup>5</sup> The trial court granted the Sheriff's motion to dismiss holding that the request for arbitration was untimely. Citing to a long line of Florida cases, the appellate Court stated "... the issue of timeliness was a question for an arbitrator, not a trial court." The Court also stated that this is true, "... even if the time requirement for arbitration is labeled a condition precedent." The general rule in Florida is that the arbitrator and not the court decides if the demand for arbitration was timely or not.

May A Party Agree To Arbitration And Then Months Later, Seek To Remove It To Court? In *Victor v. Dean Witter Reynolds, Inc.*, that is what occurred.<sup>6</sup> In *Victor*, Dean Witter was actively involved in seven (7) months of arbitration under the contractual terms of its own agreement, insisting that the issues be arbitrated before changing its argument that a court and not the arbitrator should decide if a certain probate statute of limitations barred arbitration. Although governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-11, this instructive Florida decision held that "... the question whether an action is time-barred due to a state statute of

*continued, next page*

## ARBITRATION

from previous page

limitations is a question for the arbitrator and not the courts.”<sup>7</sup>

The Court cited to *Estate of Vernon v. Shearson, Lehman Bros., Inc.*, which was relied upon by Dean Witter in its brief for the proposition that where the Federal Arbitration Act (“FAA”) governed, the court and not the arbitrator decides statute of limitations issues.<sup>8</sup> However, the Court focused on the arbitration provision and reiterated that “[b]y agreement, however, Dean Witter stipulated that any controversy would be arbitrated; thus, by agreement, its option to take the statute of limitations issue into court became limited.”<sup>9</sup>

Besides the FAA argument, the Plaintiffs also argued that Dean Witter waived its right to have a judicial determination of its statute of limitations defense, since it participated in seven (7) months of arbitration process. Here, Dean Witter insisted that the arbitration be held, participated in the selection of the arbitration panel, and then months later, raised the statute of limitations defense. The Court had no trouble finding that Dean Witter waived its right to a judicial determination.

The lesson here is that if a party acts in a way inconsistent with its argument and legal position, a court and an arbitrator will have little difficulty ruling against that party who seeks to reverse course.

Is A Showing Of Prejudice A Precondition To Waiver? In *Raymond James Financial Services, Inc. v. Steven W. Saldukas*, the Florida Supreme Court held that “... an arbitration right must be safeguarded by a party who seeks to rely upon that right and the party must not act inconsistently with the right.”<sup>10</sup> This case involved an arbitration brought by two account holders against an investment company over alleged improper investment transactions. Once the plaintiffs made their claims, Raymond James sought to force the case into state court, making various filings in the court, and alleging that there was no arbitration provision applicable to this claim. Thereafter, the plaintiffs filed suit in state court and Raymond James filed a motion to

dismiss making various assertions, but it did not assert that the case should be arbitrated. Among other things, there was also a dispute over whether one of the plaintiffs had a right to bring the suit which, likely distracted Raymond James’ counsel.

The trial court denied Raymond James’ motion to dismiss one of the plaintiffs and ordered the company to file responsive pleadings, at which point, Raymond James filed a motion to compel arbitration.

The plaintiffs objected to the motion to compel arbitration and argued that Raymond James had waived its right to arbitrate by initially refusing to arbitrate the claims, by repeatedly asserting that the plaintiffs had no right to arbitrate and by threatening a lawsuit to enjoin arbitration should the parties persist in their arbitration proceeding. After hearing these arguments, the trial court denied Raymond James’ motion to compel arbitration.

The Florida Supreme Court addressed two issues. First, to resolve a conflict among the district courts with respect to the requirement for proof of prejudice in order for there to be a waiver of the right to arbitrate, and second to determine if Raymond James waived its right to arbitrate. Citing to *Seifert*, the Court reiterated the three elements to consider in ruling on a motion to compel arbitration of a given dispute: (1) whether a valid written agreement to arbitrate exists; (2) whether an arbitrable issue exists; and (3) whether the right to arbitration was waived.<sup>11</sup> The Court further stated that:

“...we have not held that there is a requirement for proof of prejudice in order for there to be an effective waiver of the right to arbitrate. We have defined “waiver” as the voluntary and intentional relinquishment of a known right or conduct which implies the voluntary and intentional relinquishment of a known right. ... The right to arbitration, like any contract right, can be waived.”<sup>12</sup>

The Court then held that no showing of prejudice was required to show a waiver of the right to arbitrate. The Court also held that under the totality

of the circumstances in this case, Raymond James had acted inconsistently with the arbitration right and therefore, could not arbitrate this dispute. “The arbitration right must be safeguarded by a party who seeks to rely upon that right and the party must not act inconsistently with the right.”<sup>13</sup>

What Is a “Reasonable Time” To Demand Arbitration If No Contractual Time Is Specified? May A Preemptory Judicial Suit By A Future Defendant, Undermine The Future Plaintiff’s Right To Arbitrate? In *The Hillier Group, Inc. v. Torcon, Inc.*, the contract provided for a detailed procedure for mediation and arbitration.<sup>14</sup> However an exact time period was not specified. The contract stated that the demand for arbitration “...shall be made within a reasonable time after the claim, dispute or other matter in question has arisen. In no event shall the demand for arbitration be made after the date when institution of legal or equitable proceedings ... would be barred by the applicable statutes of repose or limitation.”<sup>15</sup> After being sued by Torcon, Hillier sought to arbitrate its claims and argued that since the defendant never filed an action for arbitration, the time to bring such a demand had not expired. In other words, it argued that because the defendant didn’t seek to arbitrate a claim, the plaintiff should not be time barred from bringing its demand to arbitrate either. The question was did Hillier waive its right to arbitrate?

The Court held no, stating “[w]e think that the adoption of the rule that a defending party waives the right to arbitration by failing to demand it prior to being sued would be unwise. Such a rule would enable one of the contracting parties to circumvent an arbitration provision by filing a lawsuit before the other party filed a demand, thereby encouraging the immediate resort to litigation as soon as a dispute became a glimmer on the horizon. ... Thus, as in this case, where the arbitration clause ... requires only a reasonable time within which a demand for arbitration is to be made, the party filing the lawsuit cannot argue for a waiver based on the defending party’s failure to preempt the litigation with an earlier demand for arbitration.” The Court also ruled that the arbitrator and not the court will have to decide if the demand for arbitration was timely.

continued, next page



## ARBITRATION

from previous page

Can A Non-Signatory Being Sued In Court Remove The Case To Arbitration Against A Signatory Who, Among Other Things Makes Tort Claims? Yes, according to *Tenet Healthcare Corporation, et al v. Dipnarine Maharaj, M.D. and Stem Cell, Inc.*<sup>16</sup> In *Tenet*, a physician was terminated from his position under an employment agreement with a limited partnership. His complaint in court alleged in part, a breach of a limited partnership agreement between his medical corporation and the other medical corporation, the latter a wholly owned subsidiary of *Tenet Healthcare Corporation* and the hospital (collectively the "Hospital"). Thereafter, the physician amended his complaint, and ceased to claim a breach of contract under the limited partnership agreement presumably to avoid being forced into arbitrating his claims. However, the amended complaint continued to allege that the Hospital breached its bylaws in revoking the physician's privileges without a prior hearing; that all the appellants tortiously interfered with the physician's business relationships by wrongfully appropriating his medical practice; that the general partner breached its fiduciary duty to the physician "by virtue of the limited partnership arrangement among them;" and that the appellants fraudulently transferred the certain partnership assets.<sup>17</sup>

Both the employment agreement and the limited partnership agreement contained broad arbitration provisions. The former provided in part: "[t]he parties firmly desire to resolve all disputes without resort to litigation in order to protect their respective business reputations and the confidential nature of ... operations. Accordingly, and except as otherwise provided herein, any controversy or claim arising out of or in connection with this Agreement, or the alleged breach thereof, shall be settled by arbitration . . . ."<sup>18</sup> The limited partnership agreement provided: "[a]ll disputes between the parties arising under this Agreement shall be resolved through binding arbitration ... Notwithstanding anything to the contrary contained herein, if, due to a breach or threatened breach or default, a party is suffering irreparable

harm for which monetary damages are inadequate, such party may petition a court of competent jurisdiction ... for injunctive relief, specific performance or equitable relief...."<sup>19</sup>

The question was whether or not, in spite of the amended complaint, there was still a sufficient nexus between the claims, and particularly the tort claims, and the contracts to subject the physician to arbitration, which is what the hospital sought to do and whether the Hospital, despite being a non-signatory to the arbitration agreement could remove the case from court? To begin its analysis, the Court cited to *Seifert* for the proposition that "the determination of whether a particular claim must be submitted to arbitration necessarily depends on the existence of some nexus between the dispute and the contract containing the arbitration clause."<sup>20</sup> The Court observed that although not all claims would be subject to arbitration, the broad arbitration clauses did not carve out torts or other causes of action.

The Court stated "[h]ere, the arbitration agreements did contemplate the claims alleged by the respective parties. The allegations in ... [the physician's] complaint implicate the various obligations allegedly owed by the appellants "by virtue of the limited partnership arrangement" among them. In other words, the agreement placed them in a unique relationship that created duties not otherwise imposed by law, such that there was a sufficient nexus between the dispute and the agreement as contemplated by *Seifert*."<sup>21</sup>

The Court then held that the subject arbitration clauses were sufficiently broad to evince the intent of the parties to arbitrate all of their claims and not just some of them thus subjecting the physician to the arbitration process sought by a non-party, instead of a judicial action, which he preferred. The Court also rejected the physician's argument that the Hospital was not subject to the arbitration agreement.

The Court held that the Hospital (the two non signatory business entities) were parties within the meaning of the arbitration clause and that they received rights and accepted obligations under the agreements. "They

were entitled to the protection of the arbitration clause not only because the claims against them arose solely in connection with their activities as officers and directors of the Transplant Institute, but also because the claims against them arose from the same set of operative facts as those claims against the Transplant Institute and the General Partner."<sup>22</sup> One can posit whether or not *Tenet* is good law or not, but the decision certainly opens the door for strategic consideration.

As this practice note illustrates, there are numerous variations on the theme of timeliness and waiver and the use of strategy when an arbitration provision is part of the litigation equation. In the health care setting, most, if not all managed care agreements, hospital agreements just to name a few, have arbitration provisions. Sometimes, it is unclear when a dispute has arisen to the point where a demand for arbitration should be made in accordance with the contractual provision. For example, with a managed care provider agreement, working through the reimbursement issues is very time consuming and can easily run during the allowable time to make a demand for arbitration resulting in no meaningful recourse  
*continued, next page*

**Update your  
CLE record in  
record time!**

**CLE CREDIT POSTING**

**Discover the  
convenience of  
online posting at**

**[www.floridabar.org](http://www.floridabar.org)**

**Click "Member Profile" at top right  
Click "CLE Activity Posting" link  
Login and Post Credits**

**REMINDER: FLORIDA BAR  
CLE ATTENDANCE CREDITS  
ARE POSTED AUTOMATICALLY**

## ARBITRATION

from previous page

for the provider. A careful practitioner promptly sends a letter of non-waiver to the managed care company, which they also must sign, to stay the tolling of the time to bring arbitration. The author has used a one year agreed upon period to work through reimbursement issues with managed care companies. Thus the provider's right to demand arbitration is preserved.

The practitioner should also be mindful of the myriad fact patterns which can develop, and stay vigilant to protect their client's right to arbitrate or to remove the dispute to court, if that is the best strategy.

*\*Harold E. Kaplan, Esq. is a Board Certified Health Law Attorney and former Chair of the Health Law Section. He is an arbitrator and mediator for the American Health Lawyers Association – Alternative Dispute Resolution Service and as a Florida Certified Circuit Court Mediator. His office is in Coral Springs, Florida where he represents physicians and other health care providers in a broad range of matters.*

### Endnotes:

- 1 See *Seifert v. U.S. Home Corp.*, 750 So.2nd 633 (Florida, 1999) at 636.
- 2 *Id.*
- 3 See *Abel Homes at Naranja Villas, LLC v. Anselmo Hernandez and Juaquin Llovera*, 960 So.2nd 891 (Fla. 3rd DCA, 2007) at 893.
- 4 See *Lyons v. Krathen*, 368 So.2nd 906 (Fla. 3d DCA, 1979) [missed a thirty (30) day requirement], *Seaboard Surety Co. v. Cates*, 604 So.2nd 570 (Fla. 3d DCA, 1992) [missed a thirty (30) day requirement] and *Hubbard Construction Company v. Jacobs Civil, Inc.*, 969 So.2nd 1069 (Fla. 5th DCA, 2007) [missed a twenty (20) day requirement].
- 5 *Thierry Albert Thenet v. Ken Jenne*, 968 So.2nd 46 (Fla. 4th DCA, 2007).
- 6 *Victor v. Dean Witter Reynolds, Inc.*, 606 So.2nd 681 (Fla. 5th DCA, 1992).
- 7 *Id.* at 683.
- 8 *Estate of Vernon v. Shearson, Lehman Bros., Inc.*, 587 So.2nd 1169 (Fla. 4th DCA, 1991).
- 9 *Victor v. Dean Witter Reynolds, Inc.*, 606 So.2nd 681 (Fla. 5th DCA, 1992) at 684.
- 10 *Raymond James Financial Services, Inc. v. Steven W. Saldukas*, 869 So.2nd 707 (Florida, 2005).
- 11 *Id.*
- 12 *Id.* at 711. See also, *Major League*

*Baseball v. Morsani*, 790 So.2nd 1071 (Florida 2001) at 1077, note 12., which was cited by the Florida Supreme Court in *Raymond James Financial Services, Inc. v. Steven W. Saldukas*, 869 So.2nd 707 (Florida, 2005).

13 *Id.*

14 *The Hillier Group, Inc. v. Torcon, Inc.*, 932 So.2nd 449 (Fla. 2nd DCA, 2006).

15 *Id.* at 454.

16 *Tenet Healthcare Corporation, et al v. Dipnarine Maharaj, M.D. and Stem Cell, Inc.*, 787 So.2nd 241 (Fla. 4th DCA, 2001).

17 *Id.* at 242.

18 *Id.* at 242.

19 *Id.* at 242.

20 *Id.* at 242.

21 *Id.* at 243

22 *Id.* at 243.

The Florida Bar Health Law Section Announces the

## 2010 Florida Practitioner's Health Law Handbook



The Health Law Section announces publication of the 2010 FLORIDA PRACTITIONER'S HEALTH LAW HANDBOOK, a desk reference for lawyers who need quick access into cutting edge Florida health-care law issues. Written by leading Florida health care lawyers who are expert in their fields, the 2010 FLORIDA PRACTITIONER'S HEALTH LAW HANDBOOK will soon become your go-to desktop manual when you get hit with questions about Florida health law issues. Chapters as described below will provide focus to practitioners on selected cutting edge issues in Florida:

Patient Safety Organization	James "Chet" Barclay
Florida Health Care Clinic Act	Rodger L. Hochman & Laurie J. Levin
Fraud and Abuse: A Florida Perspective	Lester J. Perling
Certificate of Need	R. Terry Rigsby
Federally Qualified Health Care Centers	William Dillon
Florida Medicaid	Walter Carfora
Asset Protection	Jonathan B. Alper
Constitutional Amendments	
Patients' Right to Know about Adverse Medical Incidents	
Public Protection from Repeated Medical Malpractice	
Claimant's Right to Fair Compensation	Bill Bell
The Rights of Patients	Louise T. Jeroslow
Integration: Tax and Physician	
Practice Organization and Acquisitions; Tax Exempt Issues	Mark A. Coel
Professional Regulation and Declaratory Statement Process	Bruce D. Lamb
Medicare, Fundamentals of a Comprehensive Program	Christine C. Whitney
Restrictive Covenants	John F. MacLennan
EMTALA and Florida Care Access To Emergency	
Care and Services	Stephanie A. Russo
Health Care Technology Contracting	Sandra P. Greenblatt

## ORDER INFORMATION

Please mail this form to: Ashlea Wiley, Program Administrator, Health Law Section, The Florida Bar, 651 E. Jefferson Street, Tallahassee, FL 32399 with a check in the appropriate amount payable to The Florida Bar (or insert your credit card information below) and mail or fax to 850-561-5825. If you have any questions please call 850-561-5624.

Name \_\_\_\_\_ Florida Bar# \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

### COST INFORMATION (CHECK ONE)

- Member of the Health Law Section: \$75 (plus tax) (Item # 8130002)  
 Non-section member: \$100 (plus tax) (Item # 8130003)

### METHOD OF PAYMENT (CHECK ONE)

- Check enclosed made payable to The Florida Bar  
 Credit Card:  MasterCard  Visa  AMEX  Discover

Signature: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Card No: \_\_\_\_\_

Exp. Date: \_\_\_\_/\_\_\_\_ (Month/Year) Billing Zip Code: \_\_\_\_\_

03/2010

## HEALTH INFORMATION

from page 7

later than 45 days from the discovery of the breach. While the Florida statute does seem to default to the Rule there is, at the time of writing, no case law or regulatory enforcement history that specifically addresses this issue.

### Content of Notification

Any notification required under the Rule should be written in plain language and contain the following elements:<sup>20</sup>

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
2. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type so information were involved);
3. Any steps individual should take to protect themselves from potential harm resulting from the breach;
4. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
5. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, Website or postal address.<sup>21</sup>

The above elements would meet the notification requirements of Florida law.

### Method of Notification

Both the federal Rule and Florida law are very similar with regard to the method of notifying individuals of a breach of unsecured PHI as both call for written notice and as appropriate, electronic notice. Under the Rule written notification must be by first-class mail to the individual at the last known address of the individual.<sup>22</sup> Florida law is silent as to the mailing requirements<sup>23</sup> so health care providers that

plan to provide written notification via the United States mail should do so using first-class postage. The federal Rule and Florida law both also allow for individual notification via e-mail if the individual has agreed to accept electronic notice.<sup>24</sup> Given the potential costs for providing written notification via first-class mail to a large number of individuals, health care providers may want to consider, to the extent possible, requesting that individuals with a valid email address agree to accept notice via email.

### Substitute Notification

Under the Rule, substitute notification is required in situations in which there is insufficient or out of date contact information that precludes written notification as specified above.<sup>25</sup> For situations in which a health care provider has insufficient or out of date contact information to provide written or email notification for fewer than 10 individuals the provider may provide notification through an alternative method.<sup>26</sup> For situations in which there is insufficient or out of date contact information for 10 or more individuals health care providers would be required to provide substitute notice in the form of a conspicuous posting for at least 90 days on the involved provider's website or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.<sup>27</sup> Such notice would also require the health care provider to provide individuals with access to a toll-free phone number, for at least 90 days, so that affected individuals can learn more about the breach that occurred.<sup>28</sup> In urgent situations a health care provider may provide immediate notice to affected individuals by telephone or alternate means, in addition to the more formal notice required under the Rule.<sup>29</sup>

The Florida statute also contains a somewhat similar substitute notice provision<sup>30</sup> however such provision only appears to be available in situations in which; (1) the cost to the health care provider of providing notice would exceed \$250,000.00; (2) the affected class of persons to be notified exceeds 500,000; or (3) there is not sufficient contact information for the individual to allow for direct notice.<sup>31</sup> While the federal Rule does not address the cost

of notice it appears that health care providers would be able to comply with both the Rule and the Florida statute as the Rule does address substitute notice for individuals without sufficient contact information. However, it should be noted that the Florida substitute notice provision does contain a subtle difference with regard to media notification as a means of substitute notice. Specifically, the Florida law requires that substitute notice include "notification to major statewide media".<sup>32</sup> As previously mentioned above, the Florida law would appear to default to the federal Rule as it comes from the health care provider's functional federal regulator.

### Notification to the Media

In addition to the notice and substitute notice requirements discussed above, the federal Rule also contains a required media notification obligation. In the event that a health care provider has a breach of unsecured PHI involving more than 500 residents of a state the provider must notify prominent media outlets serving the state.<sup>33</sup> Notification to the media should be provided without unreasonable delay but in no case later than 60 days after discovery of the breach.<sup>34</sup>

### Notification to the Secretary of HHS

In situations in which a breach of unsecured PHI involves 500 or more persons a health care provider would be required to notify HHS contemporaneously with the notice provided to the affected individuals.<sup>35</sup> If the breach of unsecured PHI involves less than 500 persons the health care provider should maintain a log documenting any breaches and provide notification to HHS within 60 days after the end of the calendar year.<sup>36</sup> As with other HIPAA records, health care providers should maintain copies of such logs for at least 6 years.<sup>37</sup>

### Delays in Notification Due to Law Enforcement

Both the federal rule and the Florida statute allow for the delay of any required notification if such notice would impede a criminal investigation, cause damage to national security or would otherwise be consistent with the legiti-

*continued, next page*



## HEALTH INFORMATION

from previous page

mate needs of law enforcement.<sup>38</sup> Any such delay should be appropriately documented.<sup>39</sup>

### Business Associates

Most, if not all, health care providers utilize outside persons or entities to assist the provider in the performance of their operations. Many of these outside persons or entities use, maintain, or disclose PHI in the course of the services provided to the provider. Such outside entities or persons are considered "business associates".<sup>40</sup> Both the federal Rule and the Florida statute address breaches by persons or entities that are acting as business associates.<sup>41</sup> The Rule requires that health care provider business associates that experience a breach of unsecured PHI notify the provider without unreasonable delay and in no case later than 60 days from the discovery of the breach.<sup>42</sup> Florida law would require health care provider business associates that maintain computerized data on behalf of a provider to notify the provider of a breach no later than 10 days from the discovery of the breach.<sup>43</sup> Accordingly, health care providers should require their business associates to notify them of a breach of unsecured PHI no later than 10 days from the discovery of the breach. Such requirement should be specifically addressed via a written business associate agreement between the respective health care provider and business associate. Depending on the legal relationship between the provider and a business associate the time clock of notice by the health care provider to the individual may begin to run from the date of the breach discovery by the business associate.<sup>44</sup> Accordingly, it is important for providers to require their business associates to promptly notify them of any breach even if all the details of the breach are not known at the time of notice.

### Next Steps

Health care providers should take appropriate steps to ensure that the new breach notification rule is integrated in to the provider's HIPAA compliance program. Such integration would, among other things, included the creation of appropriate policies and

procedures to address breaches of unsecured PHI, as well as appropriate training for the provider's staff.

\* **William Dillon** is a shareholder with the Tallahassee law firm of Messer, Caparello & Self, P.A. Mr. Dillon is Board Certified in Health Law and represents clients in the health care industry in a variety of matters including health information technology.

### Endnotes:

- 1 The HITECH Act is a part of the American Recovery and Reinvestment Act of 2009
- 2 45 CFR 164.402
- 3 45 CFR 164.402(1)(i)
- 4 45 CFR 164.402(1)(ii)
- 5 74 Federal Register 42744 (August 24, 2009), suggests that covered entities review OMB Memorandum M-07-16 for risk assessment factors.
- 6 Id.
- 7 45 CFR 164.402(2)(i)
- 8 817.5681(4), F.S.
- 9 817.5681(5)(a-c), F.S.
- 10 45 CFR 164.402
- 11 NIST Special Publication 800-66 Revision 1, <http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf>
- 12 45 CFR 164.404(a)
- 13 817.5681(1)(a), F.S.
- 14 45 CFR 164.404(2)(b)
- 15 817.5681(1)(a), F.S.
- 16 45 CFR 160.202(1)

- 17 45 CFR 160.203
- 18 817.5681(1)(a), F.S., and 817.5681(5)(a-c), F.S.
- 19 817.5681(9)(b), F.S.
- 20 45 CFR 164.404(2)(c)(2)
- 21 45 CFR 164.404 (c)(1)(A-E)
- 22 45 CFR 164.404 (d)(1)(i)
- 23 817.5681(6)(a), F.S.
- 24 45 CFR 164.404(d)(1) and 817.5681(6)(b), F.S.
- 25 45 CFR 164.404 (d)(2)
- 26 45 CFR 164.404(d)(2)(i)
- 27 45 CFR 164.404 (d)(2)(ii)(A)
- 28 45 CFR 164.404 (d)(2)(ii)(B)
- 29 45 CFR 164.404 (d)(3)
- 30 817.5681(6)(c), F.S.
- 31 Id.
- 32 817.5681(6)(c)(3), F.S.
- 33 45 CFR 164.406(a)
- 34 45 CFR 164.406(b)
- 35 45 CFR 164.408(b)
- 36 45 CFR 164.408(c)
- 37 45 CFR 164.530(j)(2)
- 38 45 CFR 164.412 and 817.5681(1)(a), F.S.
- 39 45 CFR 164.412(a-b)
- 40 45 CFR 160.103
- 41 45 CFR 164.410 and 817.5681(2)(a)
- 42 45 CFR 164.410(2)(b)
- 43 45 CFR 164.410(2)(b)
- 44 74 Federal Register 42754 (August 24, 2009)

This newsletter is prepared and published by the Health Law Section of The Florida Bar.

Troy Kishbaugh ..... Chair  
Lester Perling ..... Chair-Elect  
Bernabe Icaza ..... Secretary  
Cynthia Mikos ..... Treasurer  
Jeanne Helton ..... Immediate Past Chair  
Tom Clark ..... Editor  
Ashlea Wiley ..... Program Administrator  
Anthony Perez ..... Graphic Design/Layout

Statements or opinions or comments appearing herein are those of the editor and contributors and not of The Florida Bar or the Section.