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Medlaw Update

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In this Issue

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Leadership Note

From the Chair: The Ideal We All Should Carry—Creating, and Maintaining, a Reputation of High Integrity

by Alex J. Hagan

Last month, a young associate asked me what I thought to be the single most valuable piece of advice for a young lawyer. I know they regretted asking me when I responded with, "Let me tell you a story."

When I first started practicing law, I had the opportunity to accompany my firm's senior partner to a DRI function. There, I watched him connect with many fellow notables of the defense bar, sharing stories and client referrals. One DRI member took me aside and said she had known my partner for many years. She described him as the embodiment of all that is good in the practice of law. She said you will never find a more honest person, and that, she said, is what everyone should want in their lawyer.

Shortly after that DRI conference, when my partner and I were on our way to a client meeting, I asked him what he thought was the most important thing a young lawyer could learn. He said he had two thoughts. The first was that we should measure our success not by how often we win, but by how often we serve the client's best interest. The second was that while it was easy to establish a reputation in the legal community, it was much more important to establish a reputation of integrity.

While I acknowledged his words, it was with some disagreement. In my mind, the most important thing seemed obvious—to win.

The matter on which I was assisting was very complex, with what I perceived to be very bad facts. As we met with various key witnesses and gathered more facts, it became apparent to me that there may be little chance at winning the matter. This realization left me disillusioned and confused as to our role. After we left the meeting, I watched as my partner deconstructed the facts and began to strategize the best way to defend the client. In so doing, he recognized that winning may be hard, but not impossible. I asked him how he felt about our chances. In response, he stated he learned long ago he did not get to write the facts. If he did, he obviously would have written them quite differently. He said that what makes the practice of law exciting and challenging is accepting the circumstances handed to you and trying to better your client's position.

As the case progressed, I saw his words put into action. I watched him create a defense theme, using the facts that we gathered in our investigation, to provide what could be accepted by at least one juror as a reasonable explanation for the outcome. The end result was a favorable resolution of the matter for our client.

After the matter was concluded, the client asked us to return for a postmortem to discuss lessons learned and improvements to be made. One person at that meeting asked my partner what he thought allowed for the favorable result. My partner responded that the practice of law was neither black nor white, but rather a little of both swirled among a lot of grey. When lawyers look at cases, they see facts, which is accurate. But what is also accurate is behind those facts, there are people—people who designed the product; people who performed the procedure; people who interpreted the data. If presented well, jurors will relate, understand, and often empathize with those people. After all, jurors were human long before they were jurors. What he did not say, but what I knew, is that the lawyer presenting those facts and those defenses is critical.

My partner shared with me privately that the most important thing for me to take away from this experience is that nothing we had just accomplished would have been possible if the court, our client, opposing counsel, and the jury did not know us to be truthful. It was that integrity that allowed us to have civil discourse with our opposition and with the court. It was that reputation that created the trust in our client. A reputation for integrity is the single most valuable asset a lawyer can have. That reputation must be earned and is invaluable once it is. That reputation must also be nurtured and protected every day. Once damaged or lost, it is nearly impossible to repair.

Those words have stayed with me every day that I practice law. It is those words that guide the frank discussions with the client. It is those words that have made me strive toward a civil discourse with opposing counsel. On this subject, I still feel like a new lawyer, struggling every day to create and maintain a reputation of integrity. But as my partner said, that is one of the challenges of our profession.

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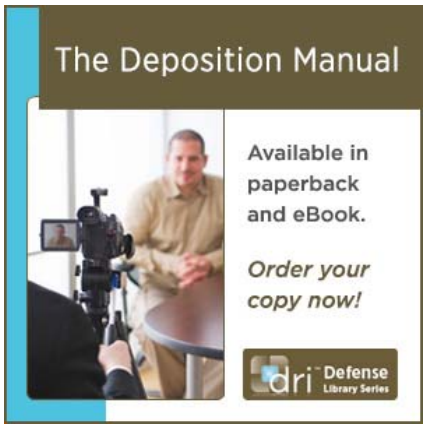

DRI Social Links

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Over the past year, I have had the distinct honor of working with many great lawyers as we have advanced the goals of our DRI committee and identified topics and speakers for numerous seminars. With each meeting, each seminar, and each opportunity to interact with my fellow DRI members, I see that we all carry this same ideal, to create and maintain a reputation of high integrity. What I was taught early on by my partner appears to be pervasive among the leaders in our DRI community.

When my story ended, I looked at the associate. And yes, I could tell he regretted asking the question. However, when he opens the file I gave him and accompanies my partner and me to our next client meeting, I think he will see what I did not when I started practicing law.

This article is dedicated to Dick Ellis, my mentor, my partner, and my friend.

Articles of Note

The Medical Peer Review Privilege Survives A New Attack – The Crime-Fraud Exception

by Matthew D. Murphy

In October of 2016, the South Dakota Supreme Court rejected a multifaceted challenge to South Dakota's medical peer review privilege. *Novotny v. Sacred Heart Health Services,* 2016 SD 75, 887 N.W.2d 83. The holding was noteworthy because, in addition to rejecting the more traditional constitutional challenges often made to the privilege, it provided the first appellate level analysis of whether or not this type of privilege would yield to a crime-fraud exception. *Id.*

The Unnecessary Surgery and Medical Conspiracy Lawsuit

Lawsuits based upon allegations that a health care provider intentionally completed and billed for an unnecessary procedure, or that a hospital knowingly let it happen, have traditionally been prosecuted by the government in the False Claims Act context. However, in 2004, large-scale private litigation made headlines when over 750 plaintiffs brought lawsuits claiming profit-driven surgeons at the Redding Medical Center in California harmed each of them by intentionally completing unnecessary cardiac procedures. Todd Wallack, *Hospital settles with patients: $395million/Lawsuit said Tenet performed hundreds of needless surgeries,* SFGate (Dec. 22, 2004), http://www.sfgate.com/health/article/Hospital-settles-with-patients-395-million-2662083.php; 129 Am. Jur. Proof of Facts 3d 1, §1 (2012). The Redding Medical Center, and its owner Tenet Healthcare Corporation, paid $395 million to resolve the cases. Id.

The private, unnecessary surgery and medical conspiracy lawsuit trend has recently picked up steam. Examples include the Sossan cases from South Dakota, on which this article focuses; the Durrani cases in Ohio (involving 400-500 plaintiffs alleging unnecessary spine surgery); the St. Joseph's London hospital cases in Kentucky (involving about 400 plaintiffs and allegations of unnecessary cardiac procedures); and a putative class suit involving unnecessary LASIK surgery in South Carolina.

Generally, an unnecessary surgery and medical conspiracy suit involves a large number of plaintiffs, each making factually similar claims about being fraudulently induced into undergoing an unnecessary procedure or surgery. The suits often lump the defendants together and allege that they all colluded with the physician for financial gain, and/or that the hospital defendants recklessly allowed the scheme to develop by failing to properly credential and monitor the bad acting physician. *See, e.g.,* Jodine Mayberry, *Hundreds of Spinal Surgery Malpractice Suits Refiled in Ohio Against Fugitive Doctor,* 11 No. 14 Westlaw Journal Medical Malpractice 1 (2015) (discussing the Durrani litigation); *Novotny v. Sossan, et al,* 2017 WL 2840761 (S.D. Cir. Court) (amended complaint filed in the Sossan litigation). When these cases get to trial, they generally proceed in a bifurcated fashion, similar to a negligent credentialing case, with the plaintiff first being forced to prove the surgery was unnecessary. *E.g. Kranbuhl-McKee v. Durrani,* 2016 WL 4179783 (Ohio Ct. App. 2016); *Martin v. Durrani,* 2016 WL 4426970 (Ohio Ct. App. 2016); *Shell v. Durrani,* 2015 WL 5786897 (Ohio Ct. App. 2015).

As with any case involving allegations of improper credentialing or monitoring of a physician, plaintiffs in an unnecessary surgery suit will inevitably seek discovery of information likely protected by a given state's peer review privilege. *See Sevilla v. U.S.,* 852 F.Supp.2d 1057, 1060-61 (N.D.Ill. 2012) (noting, as of 2012, the legislature in every state had created some form of peer review protection). In doing so, they will likely come forward with challenges similar to those seen in the negligent credentialing context. *See, e.g. Ex Parte Qureshi,* 768 So.2d 374 (Ala. 2000) (rejecting a plaintiffs' claim that Alabama's peer review privilege is unconstitutional); *Cawthorn v. Catholic Health Initiatives Iowa Corp.,* 806 N.W.2d 282 (Iowa 2011) (disagreeing with the plaintiff's claim that the privilege was waived because Iowa's peer review privilege is not waivable) .

This is exactly what happened in the Sossan cases in South Dakota.

The Novotny Decision in South Dakota

The 35+ plaintiffs in the Sossan cases alleged that two hospitals, and a number of independent physicians, conspired to make money off of Dr. Allen Sossan's practice of allegedly inducing patients to undergo unnecessary spine surgery. *Novotny v. Sossan et al,* 2017 WL 2840761 (S.D. Cir. Court) (Amended Complaint). Almost immediately after the first wave of Sossan suits were commenced, the plaintiffs sought protected peer review information. The plaintiffs argued that South Dakota's peer

review statutes are unconstitutional and, to avoid abuse of the privilege, must yield to a crime-fraud exception. The trial court agreed and pierced the privilege. *Novotny,* 2016 S.D. 75, ¶3, 887 N.W.2d at 86-87.

The South Dakota Supreme Court (the "Court") granted an interlocutory appeal and subsequently rejected the lower court's holding. Its opinion first analyzed the contours of South Dakota's peer review protection, ultimately providing guidance on what types of information are and are not within the privilege's reach. *Id.* at ¶¶6-13, at 87-90. Consistent with law from other jurisdictions, the Court concluded that South Dakota's privilege allows plaintiffs to gather and use information to support improper credentialing type claims from outside, independent sources; however, plaintiffs are barred from gathering information from an actual peer review committee and/or generated "by or at the behest of a peer review committee." *Id.* at ¶¶10-13, at 89-90.

Next, the Court addressed the plaintiffs' assertion that the privilege violated their procedural due process rights. In making this argument, the plaintiffs' asked the Court to weigh the "public policy of peer review against their need for evidence and of revealing instances of bad faith peer review." *Id.* at ¶16, at 91. The Court did not take the bait, finding that the plaintiffs had not even satisfied the initial elements of the analysis because they failed to set forth a protected liberty or property interest which they were allegedly being deprived. *Id.* Indeed, the only right the plaintiffs seemed to suggest the privilege impugned was their alleged right "to have a remedy by due course of law," which the Court concluded was governed by open courts analysis, not procedural due process. *Id.*

The Court next analyzed the plaintiffs' open courts challenge. *Id.* at ¶¶17-19, at 91-93. The plaintiffs contended that this right was violated because the privilege deprived "them of the best and most relevant information to establish their claim of fraud and deceit or that the peer review committees here acted improperly or in bad faith." *Id.* at ¶19, at 92. Even though this argument resonated with the lower court, the reviewing Court rejected it wholesale, disagreeing with the plaintiffs' claim that they had some form of constitutional right to access "the best and most relevant information" for pursuing their claims. *Id.* at ¶21, at 93. In other words, the open courts challenge gained little traction because the peer review protection did not lock the door to the courthouse by abolishing the plaintiffs' claims altogether; it merely restricted their ability to gather and use certain evidence. *Id.*

Finally, the Court discussed the crime-fraud exception in light of the circuit court's feelings that it is necessary to "ensure the privilege is not abused." *Id.* at ¶22. On this point, the plaintiffs pointed to the attorney-client privilege and historical case law analyzing the crime-fraud exception in that context. *Id.* In rejecting this argument, the Court noted that in South Dakota, like elsewhere, the crime-fraud exception to the attorney-client privilege is codified, not judicially enacted. *Id.* The Court then reasoned, being as the peer review privilege does not violate any of the plaintiffs' constitutional rights, carving out an exception to the privilege is not something the judiciary should be involved with, as it is a "task better left for the Legislature, which by statute created" the privilege in the first place. *Id.* at ¶23.

Only one other case appears to have considered, albeit in dicta, the crime-fraud exception in a similar context. *Smith ex rel. Smith v. U.S.* 193 F.R.D. 201, 209-212 (D. Del. 2000). In that case, the Delaware court rejected the exception because the plaintiffs did not satisfy the elements necessary for its use, making any actual determination of whether or not the exception could actually pierce the privilege moot. *Id.* Recognizing this, the *Smith* court preceded its substantive discussion by noting that it was "assuming" the crime-fraud exception could apply, without actually making a determination on the issue. *Id.* at 210.

Consequently, it appears *Novotny* is the only appellate level decision to have ruled upon whether or not the crime-fraud exception can be applied to undermine the peer review privilege. This fact, along with the South Dakota Supreme Court's categorical rejection of the plaintiffs' other constitutional challenges to the privilege, make *Novotny* an important and useful tool in the discovery fight that is sure to occur in the traditional, negligent credentialing case, and in the trending, unnecessary surgery case.

A Class a Day Keeps the Lawyer Away: The Need for Interdisciplinary Legal Education in Medical School

by Kaitlyn N. Pytlak

Introduction

In the ever present war between disciplines, it is often said that medical students would *not be caught dead* in a law school, and vice versa. Over the years, medical students have euphorically claimed the category of being inclined toward mathematics and science, while the law students have unfurled their flag and professed their allegiance to the humanities and critical-thinking. However, what if this decades-long school of thinking was wrong? What if that these two fields of study were not independently exclusive, but rather mutually symbiotic? What if a law class per day could keep the lawyer away?

During the four years of medical school, students are exposed to countless hours of classes focused on treatment techniques, clinical rotations, and medical terminology. Yet, when the stress of medical school is over, most physicians enter a world full of government regulations, malpractice claims, and

mountains of paperwork. Just as healthcare lawyers need to possess a solid knowledge base of the procedures at issue in their cases, physicians also should have a general understanding of the complex legal structure in the healthcare system. As such, medical students should be exposed to some legal education in an effort to spread awareness about the interconnectedness of law and medicine.

Today's Assignment: The Current Divide Between Law and Medicine

Although ethics and medicine have existed coextensively since the time of Hippocrates, it was not until 1985 that ethics became a required subject in medical schools across the United States. In making their decision, the Liaison Committee on Medical Education (LCME) and the American Medical Association (AMA) examined "changes in the societal and ideological context of medical practice," "new technical capabilities (such as genetic screening or fetal organ donation)," and "a complex network of providers, insurers and health care monitors under new legal and regulatory control." Despite the content of these courses being varied, the point was clear—ethics was important and its courses were essentially universal among medical students.

Conversely, despite the influx of regulatory control and the increase in medical malpractice cases, the majority of medical schools do not require courses in law or legal studies. However, many students will be sued for medical malpractice at some point in their career, and all will encounter state and federal regulations, issues with informed consent, and various forms of contracts. Because of this lack of education, most physicians do not encounter the legal aspects of their chosen career until after they have left the hallowed halls of their medical school.

As attorneys, we understand that the law is not for the faint of heart, and even the most seasoned physician can be intimidated when faced with their first lawsuit, Medicare audit, or even a patient complaint. Some physicians have even documented the experience in op-eds, books, and seminars. In a 2009 *New York Times* article, one physician recounted her first lawsuit as "devastating," "paralyzing," and "discombobulating." In fact, although not directly because of the case, this physician even called it quits on her primary care practice after thirty years of being in practice. One cannot say with certainty that legal education could have prevented the aforementioned lawsuit; however, being equipped with a core understanding of legal principles could have made the experience manageable.

Back to School: Why Medical Students Should Take Law Classes

As illustrated above, navigating the waters of the legal system can be a treacherous journey for medical professionals who have no background of the legal system. The introduction of legal courses in medical schools could alter the experience and make the process more manageable. Nevertheless, just as with ethics classes, law courses will not eliminate lawsuits or eradicate federal regulations, but they will mend the divide between medicine and law. As an article in *Academic Medicine* once noted, "familiarity with jurisprudence helps physicians practice medicine well, collaborate productively with lawyers, and be more effective in public discourse about health care delivery."

Contemporary medicine, with its ever-changing technology and unbridled regulations, can be confusing and our healthcare professionals need to be at the forefront of understanding. Essentially, if they are unable to adequately process the healthcare system, then they are unable to provide complete care to their patients. For example, many physicians cannot verbalize the definition of negligence or standard of care. To change this, the complexities of the legal system need to be broken down and introduced to medical students who will soon be in the midst of the law-governed healthcare system. The integration of law and medicine will encourage communications between disciplines, assist in increasing the knowledge base of both lawyers and healthcare workers, and prevent avoidable and ignorance-related grievances. In the end, medical students do not need to obtain their law degree, but should simply know enough about the law to keep abreast of changing laws.

Tonight's Homework: Suggestions for Incorporating Law into Medical School

Some medical schools have already been successful in incorporating legal studies into the medical classroom. In spite of this, one question lingers: *How do we teach law to medical students and what should we teach them?* Although this may seem trite, one cannot argue that the differences between medical students and law students are well-defined and oft-discussed. As mentioned above, medical students do not need the depth or specificity that law students need, just an understanding of the legal scenarios they may encounter in the field of medicine.

One possibility would be to treat legal education in a similar manner to ethics classes. Once it was decided that the teaching of ethics was needed in medical schools, new courses were created, and other existing classes were re-formulated to include ethics-based lessons. Similarly, medical schools could partner with law professors and legal professionals to design legal courses best suited for medical students. These classes could then be offered as required classes, just as most ethics courses.

Another possibility would be to approach the integration of law and medicine from a hands-on perspective through mock trials and depositions. For instance, some institutions, such as Johns Hopkins School of Medicine and Liberty University College of Osteopathic Medicine, have partnered with local law schools and participated in mock medical malpractice trials and depositions. Students first attend required legal lectures or courses (similar to ethics classes). Then, to give the students a "clinical-type" experience, they collaborate with law students and participate in mock legal situations. Throughout the course, the medical students are consistently encouraged to use what they have learned about the legal system and apply it to the "real-life" situation at hand. According to an *American Medical Association* article about the model used at Johns Hopkins, it was noted that "it has been a resounding success"—so successful that they are developing another course to continue

the interaction between medical and law students.

Conclusion

Ultimately, despite the continuing presence of the war between disciplines, it is becoming more and more evident that the white flag of surrender (or at least a truce) is needed. Due to our developing society and ever-changing technology, physicians will continue to be confronted with legal issues big and small. As such, medical school should recognize that to produce well-equipped physicians, medical student should be exposed to the workings of the complex legal structure in the healthcare system. Law and medicine are more interconnected today than ever before, and taking a law course in medical school could prove to be a huge asset in the asset. Maybe the old adage is right— *a class a day keeps the lawyer away.*

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Confusion Still Reigns Over "incident to" Billing*

by Luke P. Ihnen

Since 2001 the Centers for Medicare & Medicaid Services (CMS) has revised the rule regarding "incident to" billing to clarify its complex requirements. However, the regulation is still misunderstood by many providers. As a result, many physicians and their non-physician practitioners may continue to bill "incident to" services incorrectly and the costs could be a tough pill to swallow. The federal government recovered more than $1.8 billion under the False Claims Act and its *qui tam* provisions in 2016 alone. Violations of "incident to" billing protocols resulted in high profile settlements, including one for $700,000 and another for $4.4 million. This article will discuss the requirements and advantages to billing services as "incident to." It will address the confusion regarding "incident to" billing and the potential sources for the confusion. It will also discuss the potential ramifications and the legal strategies that can be developed to defend against allegations of improper billing.

I. "Incident to" Requirements

Section 1861(s)(2)(A) of the Social Security Act establishes the benefit category for "incident to" services. "Incident to" services are furnished incident to physician professional services, usually in the physician's office. The services are commonly provided by non-physician practitioners such as physician assistants or nurse practitioners, but billed as if the services were provided by the physician. Some services, like flu shots, labs, EKGs, or X-rays have their own statutory benefit categories and are not considered "incident to" services. In order to bill "incident to," the service must be a part of the normal course of treatment for that patient, and the physician must remain actively involved in the course of treatment.

"Incident to" services can only be billed for established patients and may not be billed if the patient is being seen for the first time. However, if an established patient is treated for a new problem, a problem different from the reason for the patient's initial visit, the service may not be billed as "incident to" and must be billed under the national provider identification number (NPI) for the non-physician practitioner providing the service. If the patient's treating physician is not in the office during the visit, but another physician is on site, the "incident to" service provided by a non-physician practitioner must be billed under the NPI of the supervising physician who is on site. As a result, the physician treating the patient and the supervising physician may not always be the same. If no physician is on site, the service must be billed under the NPI for the practitioner providing the service.

Despite its complex requirements, there are advantages to billing "incident to." It allows non-physician practitioners to submit claims under the physician's NPI. As a result, the practice receives reimbursement for the service provided by the non-physician practitioner at 100 percent of the Medicare Physician Fee Schedule. Claims submitted under the non-physician practitioner's NPI are only reimbursed at 85 percent of the fee schedule. In addition, non-physician practitioners that are licensed employees, leased employees, or independent contractors of the practice can bill "incident to" so long as they are supervised by a physician and not otherwise excluded from a federally funded healthcare program. This allows the practice to increase the number of patients for which it can receive the higher reimbursement rate.

II. Supervision Requirement

The confusion regarding "incident to" billing usually relates to the level of supervision that must be provided. Services must be furnished "under the *direct supervision* of the physician." Direct supervision means the physician "must be *present in the office suite and immediately available* to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed." The rule has not always been clear. Confusion still reigns regarding the supervision requirement even with the most recent clarification. It is not without reason.

The direct supervision requirement was added to the regulation in 2002. Prior to the change, the regulation read, in relevant part: "Medicare Part B pays for services and supplies *incident to* a physicians' professional services… if the services or supplies are of the type that are commonly furnished in a physician's office or clinic…."

In 2002, the regulation was expanded to read, in relevant part:

> "Medicare Part B pays for services and supplies *incident to* the service of a physician or other practitioner…Services and supplies must be furnished under the *direct supervision* of the physician (or other practitioner). The physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based."

After more than a decade, the regulation was revised again in 2015, providing:

> " *In general*, services and supplies must be furnished under the *direct supervision* of the physician (or other practitioner)… The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based."

Despite CMS's attempts to clarify the regulation, confusion regarding the supervision requirement was still present. It is possible that practices billed "incident to" claims improperly for more than ten years between rule changes.

In the most recent attempt to clarify the requirements of billing services as "incident to," CMS revised the regulation in 2016, providing:

> "In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner)… The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) *who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services*."

As a result, only the supervising physician who is on site may bill for the "incident to" service for that particular date of service.

III. Defending "incident to" Claims

Many practices may bill "incident to" claims improperly. Some improperly billed claims are the result of billing under the NPI of the patient's treating physician rather than the supervising physician. Other issues include billing "incident to" for new patients, or billing "incident to" for established patients with new problems. In addition, some providers understand the supervision requirement to mean that they must review 15 percent of their non-physician practitioner's charts.

The result of improperly billed "incident to" claims is an overpayment that must be reported and refunded in accordance with the 60-day report and refund rule or OIG Self-Disclosure. Improperly billed claims could also subject the practice to an audit, or result in liability under the False Claims Act, including its harsh fines and penalties. Attorneys with clients facing overpayment audits or other potential government action must understand the rule's precise requirements and develop strong legal arguments to defend against potential liability. The timing of the review can play an important role in the defense strategy. There are two recent issues pertaining to incident to defenses of which counsel should be aware.

A. Retroactivity

One issue is whether or not CMS can apply the 2016 rule retroactively to practices who were billing incorrectly under the treating physician and not the supervising physician, but have since corrected their practice. The United States Supreme Court has held that agencies cannot adopt retroactive rules without explicit congressional approval. The Administrative Procedure Act arguably supports a similar presumption. Despite the presumption against retroactive application of rules, courts have not applied the principle consistently. For example, in *Combs v. Commissioner of Social Security*, the Sixth Circuit held that the Social Security Administration could remove obesity from a list of presumptive disabilities and apply the change to an application filed three years earlier; however, in *National Mining Association v. Department of Labor*, the D.C. Circuit held that the Department of Labor could *not* apply new rules affecting Black Lung Benefits Act claims filed before the new rules were adopted.

Section 553 of the Administrative Procedure Act includes exemptions to the notice and comment requirement for interpretive rules. Specifically, exemptions are included for "interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice." Interpretive rules allow agencies "to explain ambiguous terms in legislative enactments without having to undertake cumbersome proceedings." Legislative (or substantive) rules on the other hand, "create rights, impose obligations, or effect a change in existing law pursuant to authority delegated by Congress."

The 2016 rule for "incident to" billing appears to interpret the prior 2002 regulation. It doesn't necessarily change existing law. In fact, CMS argues that the law has been the same since 2002 when direct supervision was first added. Whether the "incident to" rule change falls within the retroactivity exemption is untested. Challenges to agency interpretive rules have mostly failed under the principles outlined in *Chevron*. However, there may be an argument that the rule changes substantive rights by, for example, resulting in overpayments from improper billing practices. In addition, the rule went through notice and comment, the procedure for substantive rules. Accordingly, the argument is that the rule should not be applied retroactively to practices who were billing "incident to" claims improperly prior to the rule change.

B. Materiality

A second issue is whether or not submitting improperly billed "incident to" claims may be considered

"false claims" under the False Claims Act. In the past, submitting improperly billed "incident to" claims could conceivably be seen as a false claim. The 2016 United States Supreme Court ruling in *Escobar* may have put that in doubt, applying a materiality standard. In *Escobar*, the plaintiffs (and government interveners) alleged that submitting claims for services performed by unlicensed staffers were false and fraudulent under the False Claims Act. The Supreme Court held that "a misrepresentation about compliance with a statutory, regulatory, or contractual requirement *must be material* to the Government's payment decision in order to be actionable under the [Act]." The Court also noted that the "materiality standard is demanding," and "[the Act] is not an all-purpose antifraud statute, or a vehicle for punishing *garden-variety breaches of contract or regulatory violations*."

The question with regard to "incident to" billing is whether or not the improperly submitted claims are material to the government's payment decisions, and thus false claims, or a technical error resulting in a 15 percent overpayment and refund. In a case issued after *Escobar*, the Sixth Circuit noted that the False Claims Act "is not a vehicle to police *technical compliance with complex federal regulations*…." *Hobbs* involved the use of supervisory physicians by a diagnostic testing company who were not approved by the local Medicare carrier. As in *Escobar*, the government alleged that the company implicitly certified compliance with the supervising-physician requirements when it submitted the claims for reimbursement. The Court held that where "violations [of the Medicare statute] would not naturally tend to influence CMS's decision to pay on the claims, the bluntness of the False Claim Act's hefty fines and penalties makes them an inappropriate tool for ensuring compliance with *technical [] requirements*…." In another case issued after *Escobar*, *United States ex rel. Prather v. Brookdale Senior Living Communities*, the concurring opinion outlines the argument for technical noncompliance as opposed to materiality, stating that "even if [the plaintiff] is deemed to have adequately alleged a falsity, it is *merely technical noncompliance* and not a truly fraudulent scheme."

Although the argument has not been fully litigated, attorneys defending against "incident to" overpayments can argue that the improperly submitted "incident to" claims are technical noncompliance, and not material to the government's payment decisions. Accordingly, the claims would not fall under the purview of the False Claims Act and its *qui tam* provisions. More important, the provider or practice would not be subject to the harsh fines and penalties that the False Claims Act carries.

IV. Conclusion

When billed correctly, "incident to" services allow practices to service patients with non-physician practitioners while receiving the benefits as if the services were provided by the physician. When billed incorrectly, the result could be a large overpayment with additional fines and penalties. It is important that attorneys representing clients with "incident to" violations understand the complexities of the regulation. The rule changes and discrepancies have caused confusion among providers with regard to "incident to" billing. Attorneys defending against governmental audits and potential false claims violations should utilize every argument in their defense.

* * *

*This article was originally published in the American Bar Association Health Law Section April eSource. The online version of the original publication can be found at: http://www.americanbar.org/publications/aba_health_esource/2016-2017/april2017/incidentbilling.html .

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