HEALTHCARE LAW UPDATE

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STATE UPDATE

U.S. District Court Permits False Claims Act Case to Proceed Against Software Billing Company

On April 30, 2024, the United States District Court for the District of New Jersey denied a motion to dismiss a case against software provider Homecare Homebase, LLC (HCHB) for allegedly causing home health providers to submit false claims for reimbursement from Medicare, Medicaid, and private health insurance in violation of the federal False Claims Act.

The action, U.S. et al., ex rel. Mark Schieber v. Holy Redeemer Healthcare System, Inc. et al., was brought by a former employee of Holy Redeemer Healthcare System (Relator), who alleged that HCHB's software was intentionally designed to inflate reimbursement by prompting users to upcode the number of medically necessary visits. The Relator further alleged that codefendant Holy Redeemer instructed its staff to inflate reimbursement revenues when using the software.

The court denied the defendants' motion to dismiss because the Relator sufficiently asserted that the alleged conduct was a substantial factor in bringing about the submission of the false records or claims, HCHB exhibited at least deliberate ignorance to, or a reckless disregard for, the falsity of information being coded on its software in response to prompts, and upcoding visits to a greater number than what is medically necessary was material to the government payor decisions to make reimbursement payments.

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Third Circuit Holds Claims Asserted by GEICO Subject to Arbitration

In a recent decision, the United States Court of Appeals for the Third Circuit reversed three separate lower court decisions which found that an insurer's fraud claims against medical practices are not subject to arbitration under the New Jersey Insurance Fraud Prevention Act (IFPA). GEICO initiated civil lawsuits against three New Jersey healthcare providers seeking relief under the IFPA, claiming the providers engaged in a pattern of submitting fraudulent claims for PIP benefits. In the lawsuits, GEICO alleged that the providers filed exaggerated claims for medical services, billed medically unnecessary care, and engaged in illegal kickback schemes.

The three cases originated in the Federal District Court for the District of New Jersey, which held in each case that claims under the IFPA cannot be arbitrated, even if the agreements between the parties included arbitration clauses. The Third Circuit disagreed, determining that the New Jersey Supreme Court would likely allow arbitration of IFPA claims, and that arbitration is compelled by the IFPA because the law is broad and encompassing, does not carve out fraud, and explicitly includes fraud-like claims. The Third Circuit also held that because the contracts themselves included arbitration clauses, the claims are subject to an arbitration agreement and must be compelled to arbitration under the Federal Arbitration Act.

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New Jersey Doctor Convicted of Medicare Fraud in $5.4 Million Orthotics Scheme

On April 26, 2024, the U.S. Department of Justice announced that a New Jersey doctor was convicted on three counts of health care fraud and two counts of making false statements related to health care. The doctor was found guilty of causing over $5.4 million in fraudulent claims for orthotic braces ordered through a telemarketing scheme to be paid by Medicare.

In furtherance of the scheme, the doctor prescribed orthotic braces after brief telephone conversations with beneficiaries. For example, he prescribed multiple braces, including a back brace, shoulder brace, wrist brace, and knee brace, to an undercover agent after a call lasting just over a minute. In another case, he prescribed a knee brace to a Medicare beneficiary who had previously had both legs amputated. Evidence presented at trial showed that the doctor could not have diagnosed the beneficiaries or determined the medical necessity of the braces during these brief calls. Despite this, he signed prescriptions falsely indicating that the braces were medically necessary, that he had diagnosed the beneficiaries, had a plan of care for them, and recommended additional treatment. Brace supply companies then used these false prescriptions to bill Medicare more than $5.4 million.

The doctor is scheduled for sentencing on October 8, 2024 and faces a maximum penalty of 10 years in prison for each health care fraud count and five years in prison for each false statement count.

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FEDERAL UPDATE

Congress Introduces Bills to Extend Telehealth Flexibilities

A series of bills have been introduced in the United States House of Representatives that would extend or make permanent certain changes to Medicare telehealth rules that were adopted in response to the COVID-19 pandemic. The first bill, which was introduced on April 29, 2024, would permanently permit rural health clinics and federally qualified health centers to provide services via telemedicine. The second bill, which was introduced on April 30, 2024, would permanently expand the categories of healthcare provides who may bill Medicare for telehealth services, including occupational therapists, physical therapists, speech pathologists and audiologists.

Most recently, on May 16, 2024, the Subcommittee on Health of the House Committee on Energy and Commerce advanced a bill, entitled the Telehealth Modernization Act of 2024, which would extend certain telehealth flexibilities under Medicare that are currently set to expire at the end of 2024 through 2026, extend Medicare's hospital-at-home program, and allow audio-only telehealth services. The bill would also empower the Secretary of Health and Human Services to expand the types of healthcare provides who may provide telehealth services.

Regardless of which of these bills, if any, are ultimately adopted, practitioners would still be bound by the telehealth statutes and regulations of the state where they practice, including those governing permitted telehealth modalities (video, two way audio, etc.) and the types of practitioners who may provide telehealth services.

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Patients' Lawsuit Against Cigna Proceeds, but AMA and Physician Groups are Dismissed

On May 8, 2024, the U.S. District Court for the District of Connecticut ruled that the American Medical Association (AMA) and other physician organizations lack standing to sue Cigna for alleged underpayment of medical claims, but that the patients' claims may proceed.

In 2022, the AMA, state medical societies, including the Medical Society of New Jersey, and patients filed a class-action lawsuit against Cigna accusing the insurer of using lower-payment methods for non-participating physicians, leading to balance billing for patients and interfering with the patient-physician relationship. The Plaintiffs argued that Cigna's actions were rife with conflicts of interest and manipulations, leading to routine underpayments to physicians. The Plaintiff's further claimed that, while Cigna sometimes applies the contracted rates when processing claims, it does not always do so, and that this inconsistency breached fiduciary duties and violated the Employee Retirement Income Security Act of 1974, as well as state laws.

The Court dismissed the AMA and the state medical societies because they did not demonstrate a "concrete and particularized injury traceable to" Cigna's conduct. The Court found that the allegations did not show that the medical associations' physician members had suffered or would suffer a direct injury, nor that Cigna could be held liable for such an injury. The Court also dismissed the claims that physician members were harmed by the uncertainty they face when treating patients. The Court noted that this uncertainty is no greater than what is typically encountered in the modern healthcare system, where both providers and patients often remain unclear about the out-of-pocket costs for procedures until after claims are submitted, which insurers may deny for various reasons.

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15 States Challenge New HHS Rules Over "Gender Identity" Protections

On May 30, 2024, the Tennessee Attorney General announced a multi-state lawsuit challenging new regulations promulgated by the U.S. Department of Health and Human Services (HHS) under the Affordable Care Act that redefines the law's definition of "sex" to include "gender identity." The lawsuit was filed jointly by 15 states, and seeks to stay the regulations before their effective date of July 5, 2024. The regulations were announced by HHS pursuant to a final rule that was issued on April 26, 2024, and are intended to strengthen nondiscrimination protections and advance civil rights in the healthcare space. The final rule comes in response to the previous administration's actions to limit such protections under the Affordable Care Act.

According to the lawsuit, the regulations would require medical providers to perform surgeries and administer hormone drugs to both children and adults for the purpose of gender transition, regardless of a doctor's medical judgement. The new regulations would further require providers to allow patients into sex-segregated spaces, and would require health care workers to use gender-affirming pronouns. Tennessee, along with other states, currently prohibit certain procedures for minors that may be part of a minor's gender transition, such as mastectomies, and do not cover procedures or treatments such as "sex change or transformation surgery" under their Medicaid programs.

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Biden Administration Launches Reporting Tool for EMTALA Violations

Last month, the Biden Administration launched an online tool designed to allow patients to report violations of a federal law that requires emergency room doctors to provide emergency medical care to patients. At issue is the Emergency Medical Treatment and Active Labor Act (EMTALA), which dictates to Medicare-participating hospitals that "all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary," regardless of ability to pay.

After the Supreme Court repealed Roe v. Wade, the Biden Administration argued that under the EMTALA, emergency room doctors must provide abortions to pregnant women if it is determined that that abortion constitutes a "stabilizing treatment" under the EMTALA. In January, the Fifth Circuit of the United States Court of Appeals determined that the EMTALA cannot be used to require emergency room doctors to perform abortions.

The Biden Administration has appealed the Fifth Circuit's ruling to the Supreme Court. Meanwhile, the Centers for Medicare and Medicaid Services (CMS) announced that it has launched as online tool to allow individuals to "more easily file an EMTALA complaint," and included a link to the tool on CMS's website. While CMS's announcement does not specifically mention abortion, and, according to CMS's release, is only intended to "educate the public

and promote patient access to the emergency medical care which they are entitled to under federal law," the online reporting tool includes an option that allows a user to file a complaint if the individual was denied emergency abortion services.

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LEGISLATIVE AND REGULATORY UPDATE

New Jersey Patients May Receive Contraceptives Without a Prescription

In expanding access to reproductive health, New Jersey Governor Phil Murphy announced on May 20, 2024 several actions which cumulatively will allow New Jersey licensed pharmacists to provide patients with hormonal contraceptives without a prescription. Pharmacists who wish to provide hormonal contraceptives will be required to take a four hour training program focusing on patient screening, the selection of a self-administered hormonal contraceptive, and patient counseling. If a patient requests from a pharmacist a hormonal contraceptive, the pharmacist must first determine if the patient is eligible to receive the contraceptive by following a process which includes completing a screening questionnaire prepared by the New Jersey Department of Health. If the patient is approved, the pharmacist may provide an initial supply of up to three months and refills for up to nine additional months.

Additional Health Insurance Carrier Standards for Physician Specialists Introduced

Senate Bill 3416, introduced in the New Jersey Senate on June 10, 2024, would require additional network adequacy standards for health insurance carries that offer a managed care plan. If enacted, the Department of Banking and Insurance would adopt regulations to provide that covered persons have reasonable and timely access to physician specialists at in-network hospitals and facilities, including anesthesiologists, radiologists, pathologists, emergency medicine physicians, and such other services under the providers' supervision.

Protections for New Jersey Cancer Patients Introduced

The "Cancer Patient Care and Compassion Act," introduced in the New Jersey Senate on June 10, 2024, would provide certain protections for Stage III, Stage IV, and terminal cancer patients. Such protections include: (i) requiring health insurance carries to provide coverage for parenteral treatments of cancer and survivorship care plans; (ii) prohibiting residential mortgage lenders from providing a notice of intention regarding a default under a homeowner's mortgage while the homeowner is a cancer patient; (iii) dismissing a foreclosure action upon the presentation of a physician's letter certifying the homeowner is undergoing treatment; (iv) prohibiting a creditor from claiming a default for any debt against an individual undergoing treatment, so long as such debtor submits a physician letter certifying that the individual is currently undergoing treatment; (v) permitting a stay of an eviction notice up to 45 days while the cancer patient is undergoing treatment; (vi) and permitting a cancer patient the right to reinstatement to equivalent employment after a period of leave, including when Temporary Disability or Family Leave Insurance benefits were provided.

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ATTORNEY **SPOTLIGHT**

Get to know the faces and stories of the people behind the articles in each issue. This month, we invite you to meet Member Thomas Kamvosoulis and Associate Vanessa Coleman.

THOMAS KAMVOSOULIS

What is an interesting trend in Healthcare Law?

Although it might be stating the obvious, I think it is the possibility that restrictive covenants may become a relic of the past in light of the FTC's recent decision – or at least extremely limited. So much healthcare litigation over the last 10-15 years has focused on enforcing non-compete provisions so that experienced physicians who build successful practices can protect their patient and referral bases and their investment in younger practitioners. With the new rule in place, assuming it becomes fully enforceable, private practice physicians have to rethink their practice models and growth strategies so that they can remain competitive with hospitals, health systems, and multi-specialty super groups. This could mean offering more attractive work hours, larger salaries with better benefits packages, and faster partnership tracks, among other incentives. While the main focus of the FTC rule has been fewer restrictions on physician movement, it will have a cascading impact on the business of medicine writ large.

What achievement are you most proud of?

Raising a young daughter who has two working parents with demanding careers, but still making it to every drama club play and soccer game, all while continuing to grow my practice. While this seems basic, it is easy to lose sight of what is important when you spend so much time litigating high stakes cases, facilitating corporate transactions, and trying to build your profile in the legal community.

VANESSA COLEMAN

What is an interesting trend in Healthcare Law?

One interesting trend in healthcare is the integration of AI in digital health platforms to personalize patient care and improve diagnostic accuracy. However, it's crucial to address the numerous HIPAA and privacy concerns that arise from the collection and analysis of sensitive patient data, ensuring that AI applications in digital health adhere to strict regulatory standards to protect patient confidentiality and data security.

What achievement are you most proud of?

The achievement I'm most proud of is my work with non-profits, where I've had the opportunity to contribute to meaningful causes and make a positive impact in my community.

Save the Date!! The 13th Annual New Jersey Healthcare Market Review, April 3-4, 2025 at the Borgata Hotel Casino & Spa, Atlantic City, NJ! Connect with over 200 attendees comprised of hospital and ASC executives and stakeholders, physicians, practice owners/managers, and healthcare administrators. During this two-day event, industry experts will discuss timely topics and trends in the healthcare and legal space ranging from legislative issues to operating and business strategies for greater profitability. To learn more and register, please visit https://www.njhmr.com. For questions or additional information, please reach out to Jennifer Buneta at jbuneta@bracheichler.com.

On June 20, **Lani M. Dornfeld** was a presented to the Home Care Association of Florida (HCAF) on "Compliant Email & Text Messaging with Patients and Clients."

On June 19, **Isabelle Bibet-Kalinyak**, attended Becker's Healthcare's 21st Annual Spine, Orthopedic, and Pain Management-Driven ASC + The Future of Spine Conference in Chicago to connect with independent physician owners to discover how Brach Eichler can support their practice with our extensive legal experience.

On June 11, *Law360* reported on Brach Eichler's boom in litigation with the addition of insurance Counsel **Edward Ellersick**.

On June 6, Brach Eichler's Healthcare Law Practice was once again recognized among New Jersey's top healthcare law practices, ranked in top tier (Band 1) by Chambers & Partners 2024 USA Guide. Additionally, Chambers USA also recognized the following individual Healthcare members of the Firm: **John D. Fanburg**, with the highest Band 1 recognition in NJ; **Joseph Gorrell**, Senior Statespeople, and **Carol Grelecki**, Band 2.

Congratulations to Healthcare Law Associate **Robert J. Papazian** and Counsel **Edward Ellersick**, who have both joined the firm's Healthcare Litigation group.

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