

Washington Health Law Manual — Third Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 24:

Washington State

Fraud and Abuse

Prohibitions

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24.1 Chapter Summary

Almost all health care providers participate in federal or state programs related to the delivery of and payment for health care services, predominantly the Medicare and Medicaid programs. Participation in these programs requires compliance with a broad array of governmental mandates and prohibitions. The so-called “fraud and abuse” laws are a complex web of overlapping and sometimes inconsistent prohibitions set forth in federal and state statutes and regulations. These laws address activities such as billing, filing of claims, financial arrangements among providers, and relationships with government program beneficiaries. The laws carry severe civil and criminal sanctions, including civil monetary penalties, exclusion from program participation, and criminal fines and imprisonment. In addition, a government investigation of a health care provider can have serious ramifications to the provider in the form of injurious public relations, impeded financing, and expenditure of massive legal and human resources. Accordingly, providers and their legal counsel should make every effort to understand and comply with the applicable laws.

The focus of this chapter is on the Washington state health care fraud and abuse laws. While a brief overview of the federal laws is provided for context, there are numerous fine references available to health lawyers on the federal fraud and abuse laws, including treatises devoted to single statutes.¹ In addition, as healthcare laws and rules are constantly changing and evolving, practitioners should consult industry guidance frequently for updates on fraud and abuse laws and other regulatory developments. Suffice it to say that the already broad scope of these laws is likely to expand even further in the near future as a result of the recently-enacted Patient Protection and Affordable Care Act, which promises to make it easier for the government and private plaintiffs to bring and sustain lawsuits against health care providers.

24.2 Overview of Federal Fraud and Abuse Laws

The federal fraud and abuse laws and regulations go by common names such as the Anti-Kickback Law, the Stark law, the civil False Claims Act, and the Civil Monetary Penalties Law.² These laws are intended to protect the integrity of the Medicare, Medicaid, and other federal health care programs, by prohibiting conduct such as fraudulent or abusive billing practices, submission of improper claims for reimbursement, activities that may induce referrals of business paid for under the programs, and arrangements between providers that may give rise to financial conflicts of interest.

The task of interpreting health care providers’ exposure under these laws is complicated by the fact that many fraud cases are based upon the intersection of the laws with interpretive regulations promulgated by the administering governmental agencies and formal and informal subregulatory policies produced by the governmental and non-governmental³ agencies that administer the Medicare, Medicaid, and other federal health care programs. It is important, therefore, to have a working knowledge both of the applicable laws and of the published and unpublished reimbursement protocols.

For purposes of the law, the term “fraud” generally means misrepresentation of material facts. Fraud consists of intentional deception or misrepresentation that an individual knows to be false, made with knowledge that the deception could result in some unauthorized benefit to the individual or to some other person. Examples of fraud in federal health care programs include: (a) billing for services not rendered; (b) misrepresentation of services rendered; (c) deliberate application for duplicate reimbursement; and (d) false or misleading entries on provider cost reports.

¹ See, e.g., John T. Boese, *Civil False Claims and Qui Tam Actions* (3d ed.).

² See 42 U.S.C. § 1320a-7b(b), 42 U.S.C. § 1395nn, 31 U.S.C. § 3729 *et seq.* & 42 U.S.C. § 1320a-7a.

³ The Centers for Medicare and Medicaid Services (“CMS”) has overall administrative responsibility for the Medicare program, but contracts with private entities (often private insurance companies) to serve as Medicare administrative contractors, or “MACs”, that work directly with providers and beneficiaries on a day-to-day basis. The Medicaid program in Washington State is administered by the Department of Social and Health Services (“DSHS”).

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The legislative history of the fraud and abuse prohibitions suggests that Congress intended for providers or suppliers that bill Medicare or Medicaid to “have an affirmative duty to ensure that the claims for payment which they submit, or are submitted on their behalf by agents or employees, are true and accurate representations of the items or services actually provided.”⁴

24.2.1 Federal Criminal Prohibitions: The Federal Medicare-Medicaid Anti-Fraud and Abuse Statute

The federal Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 address various criminal prohibitions and resulting penalties that may be invoked against persons involved with the Medicare and Medicaid programs. The law prohibits many types of fraudulent or abusive conduct:

- (a) knowingly and willfully making or causing to be made false statements in an application for benefits or for purposes of determining rights to payment;⁵
- (b) concealing or failing to disclose knowledge of the occurrence of any event affecting a person’s right to any benefit or payment, with the intent to fraudulently secure such benefit or payment in an amount greater than is due;⁶
- (c) when submitting a claim on behalf of another, knowingly converting payments to the use and benefit of an individual other than the one for whom the person was acting;⁷
- (d) submission of claims for physician services where the provider is not a licensed physician;⁸
- (e) knowingly and willfully making or causing to be made a false representation concerning the conditions of operation for purposes of qualifying for Medicare or State health plan certification;⁹ and
- (f) paying or receiving remuneration in connection with the referral of Medicare or Medicaid business¹⁰ (the so-called “Anti-Kickback Law”).

The law also sets forth criminal sanctions for: (i) knowingly and willfully charging Medicaid a rate in excess of a State-established rate;¹¹ (ii) conditioning a Medicaid patient’s stay at a facility upon receiving consideration in addition to the Medicaid payments;¹² and (iii) knowingly, willfully and repeatedly violating terms of Medicare assignment.¹³

The law provides for substantial criminal penalties upon conviction of any violation. For conduct determined to be a felony, the violator may be sanctioned by a fine of up to \$25,000 and up to five years in prison, or both.¹⁴ For misdemeanors, the penalty may include a fine not to exceed \$10,000 and imprisonment for up to one year.¹⁵

⁴ H. Rep. No. 391, 100th Cong., 1st Sess. (Part 1) 534, OBRA 1987, P.L. 100-203.

⁵ 42 U.S.C. §§ 1320a-7b(a)(1),(2).

⁶ 42 U.S.C. § 1320a-7b(a)(3).

⁷ 42 U.S.C. § 1320a-7b(a)(4).

⁸ 42 U.S.C. § 1320a-7b(a)(5).

⁹ 42 U.S.C. § 1320a-7b(c).

¹⁰ 42 U.S.C. § 1320a-7b(b).

¹¹ 42 U.S.C. § 1320a-7b(d)(1).

¹² 42 U.S.C. § 1320a-7b(d)(2).

¹³ 42 U.S.C. § 1320a-7b(e).

¹⁴ 42 U.S.C. § 1320a-7b.

¹⁵ *Id.* The criminal prohibitions apply to violations involving virtually all “federal health care programs,” including without limitation the Medicare and Medicaid, TRICARE/CHAMPUS, and Railroad Retirement programs. The single exception to the definition of “federal health care programs” involves the Federal Employee Health Benefit Plan.

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Other criminal statutes that are not health care-specific but are often used in health care fraud prosecutions include the False Statements Act,¹⁶ the criminal False Claims Act,¹⁷ and the mail fraud and conspiracy statutes.¹⁸

24.2.2 Anti-Kickback Law

The federal Anti-kickback Law (enacted as a component of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 discussed above) merits further elaboration. This law addresses improper financial arrangements among providers made in connection with the referral of federal health care program business. The statute makes it a criminal offense to offer, pay, solicit or receive any remuneration in connection with referring an individual for medical items or services for which payment may be made by any “federal health care program,” including Medicare and Medicaid.¹⁹

The law contains specific exceptions that limit its scope, and additional regulatory “safe harbors” have also been promulgated, which include exceptions for arrangements such as bona fide employment relationships, space and equipment leases, discounts and price reductions, investment interests, personal services arrangements, and arrangements involving the subsidy of physician electronic health records, to name a few.²⁰

Courts have interpreted the law to impose liability where just one purpose of the payment was to induce referrals of services covered by a federal health care program, even where other lawful reasons for the arrangement exist.²¹ In addition, prior to the health reform legislation adopted in 2010, it was the law in the Ninth Circuit that the government must show that a party engaged in the prohibited activity with the *specific intent* to disobey the law.²² Under the two-part test set forth in *Hanlester v. Shalala*, prosecutors must prove that the defendant (1) subjectively knew that the Anti-kickback Law prohibited offering or paying remuneration to induce referrals, and (2) engaged in the prohibited conduct with the specific intent to disobey the law.²³

The 2010 Patient Protection and Affordable Care Act, however, has effectively nullified the Ninth Circuit’s “specific intent” requirement. The new legislation amends the Anti-kickback Law to specify that “a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”²⁴ The Act also specifies

¹⁶ 18 U.S.C. § 1001.

¹⁷ 18 U.S.C. § 287.

¹⁸ 18 U.S.C. §§ 371 and 1341.

¹⁹ 42 U.S.C. § 1320a-7b(b) provides that:

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickbacks, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring 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 under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer 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 under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

²⁰ For a complete list, see 42 U.S.C. § 1320a-7b(b)(3) & 42 C.F.R. § 1001.951.

²¹ *United States v. Greber*, 760 F.2d 68, 69 (3d Cir. 1985), *cert. denied*, 474 U.S. 988, 106 S. Ct. 396 (1985). The Ninth Circuit has adopted the *Greber* reasoning in *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989).

²² *Hanlester Network v. Shalala*, 51 F.3d 1390, 1400 (9th Cir. 1995).

²³ *Id.*

²⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f) (2010).

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that any claim to the federal government that includes items or services “resulting from” a violation of the Anti-kickback Law constitutes a “false or fraudulent claim” under the False Claims Act.²⁵

As noted, various statutory and regulatory “safe harbors” exist that, if satisfied, immunize certain activity from prosecution under the Anti-kickback Law. Activity that falls outside the safe harbors is not necessarily illegal, however, but will be closely scrutinized based on the totality of the facts and circumstances.

24.2.3 False Claims Act

The federal False Claims Act²⁶ (“FCA”), though not limited to activities involving healthcare fraud and abuse, is a significant enforcement tool frequently used by the Justice Department and the Department of Health and Human Services Office of Inspector General (“OIG”). The statute combines draconian penalties with a relatively relaxed standard of proof.

The law prohibits, among other things, the “knowing” submission of a false claim, the knowing use or submission of a false statement in order to get a false claim paid, or a conspiracy to defraud the United States by getting a false or fraudulent claim paid. The statute also provides that a hospital or other entity violates the FCA if the entity “knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.”²⁷

Significantly, the standard of “knowingly” is statutorily defined to make it less difficult to prove than proving intent to defraud; in fact, a person can be found to have violated the statute even if the person did not actually “know” of the false claim submission (but instead acted “in deliberate ignorance” or “reckless disregard” of the truth or falsity of the information).²⁸

Sanctions for violating the act are severe, and include per claim civil penalties of between \$5,500 and \$11,000,²⁹ as well as treble damages suffered by the government.³⁰ Thus, the civil exposure for violation of the FCA, particularly given the repetitive nature of health care billing, can be extremely high.

The False Claims Act also creates a private right of action (called a *qui tam* action) for persons who have information on the filing of a false claim against the government.³¹ The law permits a “whistleblower” to file suit on behalf of the government against the alleged perpetrators of fraud, and then provides the government with an opportunity to intervene and take over the litigation of the case. The law rewards a successful whistleblower for prosecuting the case on the government’s behalf by providing a percentage of the ultimate recovery, as well as attorney fees.³²

²⁵ *Id.*

²⁶ 31 U.S.C. §§ 3729-33; 31 U.S.C. §§ 3801 *et seq.* In addition, federal criminal statutes exist related to False Statements (18 U.S.C. § 1001) and False Claims (18 U.S.C. § 287).

²⁷ 31 U.S.C. §§ 3729(a)(7).

²⁸ 31 U.S.C. § 3729(b)(3) provides:

For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information –

- (1) has actual knowledge of the information;
- (2) acts in deliberate ignorance of the truth or falsity of the information; or
- (3) acts in reckless disregard of the truth or falsity of the information, and no proof or specific intent to defraud is required.

²⁹ 31 U.S.C. § 3729(a). In the Medicare context, the courts have calculated penalties using each invoice (and not each line item) as a separate false claim. See *U.S. v. Diamond*, 657 F. Supp. 1204 (S.D.N.Y. 1987). A single “CMS” form constitutes a “claim” under the FCA. See *U.S. v. Krizek*, 111 F.3d 934 (D.C. Cir. 1997).

³⁰ 31 U.S.C. § 3729(a).

³¹ 31 U.S.C. § 3730(b).

³² 31 U.S.C. § 3729(b) & (d). Note that there may be substantial procedural and jurisdictional impediments to *qui tam* actions, particularly if the allegations have been publicly disclosed prior to the filing of the action. 42 U.S.C. § 3730(e)(4).

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24.2.4 Stark Physician Referral Prohibitions

The law commonly referred to as the “Stark” law (after Congressman Pete Stark (D-CA)), prohibits physicians from making referrals for certain “designated health services” to entities with which the physician (or the physician’s immediate family member) has a “financial relationship,” unless an exception applies. Designated health services are defined as: (i) inpatient and outpatient hospital services; (ii) clinical laboratory services; (iii) physical therapy services; (iv) occupational therapy services; (v) diagnostic radiology services; (vi) durable medical equipment and supplies; (vii) parenteral and enteral nutrients equipment and supplies; (viii) prosthetics, orthotics, and prosthetic devices; (ix) home health services; (x) outpatient prescription drugs; and (xi) radiation therapy services and supplies.

The Stark law creates an absolute prohibition on physician referrals for designated health services reimbursed under the Medicare program where a financial arrangement fails to satisfy an exception.³³ In other words, no intent to violate the law is needed, and liability can be found for failings of the most technical nature, such as the failure to obtain a signature on a lease.

The Stark exceptions are many and complex, and have been proposed, finalized, and refined continuously from the proposal of the first “Stark II” rules in 1998³⁴ to the present. Thus, simply staying abreast of regulatory changes and agency interpretations of the rules can be a full-time occupation for health care professionals and their lawyers.

Since Stark’s enactment, providers have lacked a formal mechanism to self-report violations of the law and resolve any liability thereunder with CMS and HHS-OIG. In March 2009, the OIG clarified that its current self-disclosure protocol should not be used for disclosing Stark violations where there is no corresponding violation of the Anti-kickback Law.³⁵ That void will soon be filled, however, as the newly adopted Patient Protection and Affordable Care Act directs the OIG to work with the Secretary of Health and Human Services to establish a protocol for self-disclosure of Stark violations.³⁶

24.2.5 Civil Monetary Penalties

Health care providers or suppliers may also be subject to substantial civil monetary penalties under the Civil Monetary Penalties Law (“CMPL”).³⁷ Significantly, the CMPL adopts the FCA’s definition of “knowingly,” and thus penalties can be imposed in situations where the provider did not actually “know” that the underlying conduct was prohibited.³⁸ The administrative nature of the penalties also means that determinations of liability are made by an administrative law judge (and not a jury).

The CMPL authorizes the Secretary of Health and Human Services to assess civil monetary penalties of thousands of dollars per item or service delivered or furnished, plus an assessment of up to three times the amounts *claimed* (not necessarily paid) for each such item or service.³⁹ These administrative remedies may be imposed for the following acts, among others:

³³ Where a prohibited financial relationship exists, physicians and suppliers are prohibited from (1) making referrals of Medicare-Medicaid business for designated health services, and (2) billing for such services. In general, the penalty for violating the referral prohibitions is denial of Medicare and Medicaid payment. 42 U.S.C. § 1395nn(g)(1). Under certain conditions involving knowing circumvention schemes, civil monetary penalties and program exclusion may also be imposed.

³⁴ As originally enacted (*i.e.*, “Stark I”), the Stark law applied only to clinical laboratory services. The statute was amended in 1993 to include ten additional categories of designated health services (“Stark II”).

³⁵ “An Open Letter to Health Care Providers,” Office of Inspector General, Department of Health & Human Services, March 24, 2009. Available at <http://www.oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf>.

³⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6409 (2010).

³⁷ 42 U.S.C. § 1320a-7a.

³⁸ 42 C.F.R. § 1003.102(e). Thus, the government could seek CMPL penalties from a person against whom it has asserted a violation of the Anti-Kickback law, where proof sufficient to obtain a criminal conviction may be lacking.

³⁹ 42 U.S.C. § 1320a-7a(a).

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- (1) presenting or causing to be presented a claim under any federal health care program which the person knows or should have known was false or fraudulent, or for services not provided as claimed;⁴⁰
- (2) making a claim while being or having been excluded from the health care program;⁴¹
- (3) violating Medicare assignment agreements;⁴²
- (4) providing false or misleading information which could influence a hospital discharge decision;⁴³
- (5) arranging for or contracting with an individual or entity that the person knows, or should know, is excluded from participation in federal health care programs;⁴⁴
- (6) committing acts in violation of the Anti-kickback Law;⁴⁵ or
- (7) knowingly submitting an improper claim under Stark, where the person knows that a principal purpose of the financial arrangement is to evade the self-referral prohibitions.⁴⁶

The doctrine of vicarious liability generally applies to CMPL violations, and thus a principal is strictly liable for civil money penalties arising from violations committed by an agent, such as an employee acting within the scope of his or her employment.⁴⁷ Also, Medicare contractors and state Medicaid agencies may suspend or withhold payments under the respective programs without a prior hearing where there is “reliable evidence” of fraud or willful misrepresentation.⁴⁸

24.2.6 Federal Health Care Program Exclusion Authority

Perhaps the most powerful arrow in the government’s quiver is its ability to exclude health care providers from participation in governmental programs such as Medicare and Medicaid. The term “exclusion” means that no payment may be made under any federal health care program for any items or services either rendered by the excluded party, or rendered on the order of, or under the supervision of, an excluded physician, provided the person furnishing the item or service knew or had reason to know of the exclusion.

The federal government has broad authority to exclude providers from participation in federal programs as a penalty for having engaged in certain prohibited conduct. Exclusion is mandatory upon a felony conviction of fraud in connection with the delivery of health care items or services, or with respect to any criminal act or omission in a government health care program.⁴⁹ The Secretary retains discretion to exclude a provider in other situations, such as convictions relating to the obstruction of an investigation, submitting claims for excessive

⁴⁰ 42 U.S.C. §§ 1320a-7a(a)(1)(A) and (B).

⁴¹ 42 U.S.C. § 1320a-7a(a)(1)(D).

⁴² 42 U.S.C. § 1320a-7a(a)(2).

⁴³ 42 U.S.C. § 1320a-7a(a)(3).

⁴⁴ 42 U.S.C. § 1320a-7a(a)(6).

⁴⁵ 42 U.S.C. § 1320a-7a(a)(7). This provision therefore establishes so-called “intermediate sanctions” (civil fines) for violations of the (criminal) provisions of the Anti-kickback statute. Violators may be fined up to \$50,000 for each act, plus three times the amount of the kickback that was alleged to have been offered, paid, solicited or received. Moreover, these penalties may be imposed without the necessity of obtaining a criminal conviction.

⁴⁶ 42 U.S.C. §§ 1395nn(g)(3)-(5).

⁴⁷ 42 U.S.C. § 1320a-7a(l).

⁴⁸ Medicare regulations authorize an intermediary or carrier to suspend payments without first notifying the provider or supplier under certain circumstances. See 42 C.F.R. §§ 405.371, 405.372. In addition, federal Medicaid regulations permit state Medicaid agencies to withhold program payments from a provider without first granting administrative review (subject to contrary state laws) where there is reliable evidence of fraud or willful misrepresentation by the provider. 42 C.F.R. § 455.23.

⁴⁹ 42 U.S.C. 1320a-7(a)(3).

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charges that do not rise to the level of fraud, failure to disclose statutorily required information, and failure to provide required access to records.⁵⁰

In general, the minimum exclusion period for mandatory exclusions is five years,⁵¹ and three years for permissive exclusions.⁵² The Secretary may impose longer or shorter exclusion periods, however, to account for aggravating or mitigating circumstances.

24.3 Washington State Anti-Kickback, Self-Referral, and False Claims Statutes

Washington State law contains several provisions applicable to kickbacks, rebates, self-referrals and submission of false claims, many of which are analogous to the federal prohibitions discussed above. An understanding of the scope of these laws is necessary in order to fully advise Washington health care providers of fraud and abuse risks attendant to a given arrangement.

24.3.1 Anti-Rebating Statute (Chapter 19.68 RCW)

Washington has a brief, but hopelessly opaque, statute aimed at improper self-referrals of health care services.⁵³ This law, commonly referred to as the “anti-rebating statute,” is intended to guard against payment of unearned, secret profits in connection with the furnishing of medical services by a person licensed by the state to practice “medicine and surgery.”⁵⁴ The statute provides, in a single run-on sentence:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment.

The law contains an exception for a physician who discloses to patients any financial interests in an entity to which he or she refers.⁵⁵ In order to qualify for the exception, a physician must:

- (1) Affirmatively disclose to the patient, in writing, the fact that he or she has a financial interest in the entity to which the physician is referring the patient;
- (2) Provide the patient with a list of effective alternative facilities;
- (3) Inform the patient that he or she has the option to use one of the alternative facilities; and
- (4) Assure the patient that he or she will not be treated differently by the physician if the patient chooses one of the alternative facilities.⁵⁶

⁵⁰ 42 U.S.C. § 1320a-7(b).

⁵¹ 42 U.S.C. § 1320a-7(c)(3). The Secretary may waive the exclusion where the targeted individual or entity is a sole community physician or sole source of “essential specialized services” in a given community. 42 U.S.C. § 1320a-7(c)(3)(B).

⁵² 42 U.S.C. § 1320a-7(c)(3)(D).

⁵³ See Chapter 19.68 RCW.

⁵⁴ See Wash. AGO 1988 No. 28 at 3 (citing *Recent Development*, 45 Wash. L. Rev. 838, 839 (1970)).

⁵⁵ See RCW 19.68.010(2).

⁵⁶ RCW 19.68.010.

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In addition, the statute itself states that “it is not intended to prohibit two or more licensees who practice their profession as copartners to charge or collect compensation for any professional services by any member of the firm, or to prohibit a licensee who employs another licensee to charge or collect compensation for professional services rendered by the employee licensee.”⁵⁷

Violation of the anti-rebating law is a misdemeanor.⁵⁸ To date, no state enforcement actions have been brought based upon this statute, but the Washington State Attorney General (AG) has issued a number of advisory opinions on the scope of the statute. In addition, the statute has been invoked by parties in private litigation, with three resulting Supreme Court opinions.

24.3.1.1 Attorney General Opinions

The AG’s four opinions concerning chapter 19.68 RCW address the law’s applicability to various professional arrangements, including the ownership of a nursing home by a licensed physician, a referral arrangement between an optometrist and an ophthalmologist, an infusion therapy company, and a referral arrangement between a physician and a pathologist.

Wash. AGO 1975 No. 24 (Nov. 28, 1975)

In its first of four opinions regarding chapter 19.68 RCW, the AG addresses whether the anti- rebating law prohibits a physician from owning part or all of a nursing home in which the physician is responsible for patient care. The AG concluded that the physician ownership did not *per se* implicate the statute: “Simply stated, it is not ownership that is restricted by the law but rather the physician’s financial benefit derived from referring or supplying patients.”

In addressing whether chapter 19.68 RCW prohibits a physician from receiving a profit from “furnishing” medical care at the nursing home, the AG drew a distinction between receiving a profit in connection with the “referral of patients,” and receiving a profit in connection with “furnishing” care. Thus:

Provided that there is no referral, a physician may receive a financial benefit when the institution in which he has a financial interest furnishes services or goods that are not prescribed by the physician. The physician can also receive a financial benefit for services performed by him or rendered by a licensed employee of the physician.

Conversely, however, a physician is not entitled to receive a financial benefit from the services or goods furnished to patients of an institution in which the physician holds some ownership interest when the physician prescribes the services or goods that the institution furnishes to the patient, or when the physician refers the patient to the institution.

Further, RCW 19.68.010 prohibits a physician “from receiving, directly or indirectly, any valuable consideration as the result of either the sale, rental or other furnishing to the patient of any goods, services or supplies prescribed for medical diagnosis, care or treatment or the referral of the patient to any person or firm.” Thus, if the physician is “furnishing” medical supplies or services to a patient, the “physician can only furnish such supplies or services at the actual cost thereof.”

⁵⁷ RCW 19.68.040.

⁵⁸ RCW 19.68.010(3).

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Wash. AGO 1988 No. 28 (Nov. 14, 1988)

In its second opinion letter, the AG addresses whether an agreement by an optometrist to refer patients to an ophthalmologist for surgery with the understanding that the referring optometrist would provide post-operative care violated chapter 19.68 RCW or RCW 18.130.180(21) (unprofessional conduct for any license holder by violation of RCW 19.68).⁵⁹

The AG first reviewed the legislative intent articulated in RCW 19.68.040, namely, to protect the public from hidden or inflated charges by health care professionals. In light of that intent, the AG focused on whether the optometrist or the ophthalmologist would profit from services other than those they themselves actually rendered. The AG concluded that the referral did not result in any actual rebate or unearned charges. Thus, “[t]he referral does not, by itself, result in any hidden or inflated charges, unnecessary surgery or care, or profits for services not rendered by the referring professional.”

Wash. AGO 1992 No. 30 (Dec. 22, 1992)

In its third opinion, the AG addresses three questions: (1) does chapter 19.68 RCW prohibit physicians from referring their patients to an infusion therapy company where the physicians are shareholders; (2) does the answer to question (1) change if the physicians supervise the infusion therapy services; and (3) does chapter 19.68 RCW prohibit a physician from receiving a set fee from the infusion therapy company for providing services to the company’s patients?

In response to the first question, the AG relied upon the Washington Supreme Court’s decision in *Day v. Inland Empire Optical, Inc.*⁶⁰ (discussed below). The AG saw little difference between the practice described in question (1) and the practices found to be illegal in *Day*. Thus, a physician referring his or her patient to an infusion therapy company where the physician holds stock would violate chapter 19.68 RCW.

Regarding the second question, the AG concluded that to avoid violating the anti-rebate statute, the services of the infusion therapy company’s nurses must be deemed to be those of the supervising physician, the physician’s partner, or the physician’s employee. In order for a nurse’s services to be considered those of the physician’s employee, the physician must exercise actual and exclusive control over the nurse’s performance. Mere “supervision” by the physician would not be enough.

As to the third question, the AG determined that the anti-rebating statute does not prohibit an infusion therapy company from paying a physician for services, as long as the physician actually performs the services, receives fair market value payment for the services, and does not receive duplicate payment from other sources. Although the opinion did not address physician ownership in the infusion therapy company under this scenario, the AG presumably assumed that the referring physician did not have an ownership interest in the company. If he or she had such an interest, then the AG likely would have opined that the physician would be prohibited from making a profit on services or supplies that the physician had prescribed or furnished under the same reasoning described above in Wash. AGO 1975 No. 24.

⁵⁹ The opinion also addressed the issue the Medical Disciplinary Board’s authority related to the practice of optometry and the scope of practice and post-operative responsibilities of ophthalmologists; however, these issues are not relevant to the discussion of RCW 19.68.

⁶⁰ 76 Wn.2d 407, 456 P.2d 1011 (1969).

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Wash. AGO 2005 No. 13 (Sept. 8, 2005)

The AG's most recent opinion addresses (i) whether chapter 19.68 RCW prohibits a referring physician from marking up to a patient a pathologist's charge to the referring physician for diagnostic or screening services performed or supervised by a pathologist on the patient's tissue specimen, where the pathologist is neither employed nor supervised by the referring physician; and (2) whether chapter 19.68 RCW prohibits a referring physician from billing for diagnostic or screening services performed or supervised by an independently practicing pathologist on a patient's tissue specimen – even if the referring physician does not mark up the charges.

The AG answered the first question yes, and the second question no. The AG cited the legislative intent section of the law, the Washington Supreme Court's opinion in *Day*, and the AG's own 1992 Opinion, AGO 1992 No. 30. The AG determined that 19.68 RCW does not prohibit a physician from billing for a pathologist's services where those charges are “merely being passed through the pathologist to the referring physician, and then to the patient.” Conversely, where the physician is paid more than warranted for the pathology services, an inference would arise that the excess fees represented a rebate, refund, commission, unearned discount or profit in connection with the referral of patients. To avoid this inference, the AG concluded that “pass through” charges should be specifically identified as relating to pathology services, and the referring physician is not permitted to mark up the pathologist's charges.

The AG's opinion is consistent with the Supreme Court's reasoning in *Wright v. Jeckle* (discussed below), decided only one year later in 2006. Both opinions indicate that physicians should earn a profit only from services they actually render. While *unearned* profits from referrals to third parties are prohibited under the anti-rebating statute, physicians are not prohibited from profiting from their own treatment of patients or providing goods or services to their patients.

24.3.1.2 Judicial Interpretation

Providers should keep in mind that there is no reported case of State action against a provider under the anti-rebating statute. Each of the court cases discussed in this section was a private action brought by competing providers or, in the case of *Wright v. Jeckle*, by the physician's patients. Thus, even though the State appears to be rather passive in policing compliance with the statute, providers should be aware that their competitors and patients may be bolder.

Only three reported opinions have interpreted the law to date: *Day v. Inland Empire Optical, Inc.*,⁶¹ *Wright v. Jeckle*,⁶² and *Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Associates, P.L.L.C.*⁶³ Though few in number, the cases provide some clarification as to the meaning of an otherwise inscrutable statute. In particular, after the Supreme Court's most recent opinion *Columbia Physical Therapy*, providers may now have more confidence entering into employment arrangements with providers of ancillary services (*e.g.*, physical therapists) without risking liability for inappropriate “profit sharing” under the law.

⁶¹ 76 Wn.2d 407, 456 P.2d 1011 (1969).

⁶² 158 Wn.2d 375, 144 P.3d 301 (2006).

⁶³ --- P.3d ---, 2010 WL 964068 (Wash. 2010).

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i. Day v. Inland Empire Optical, Inc.

In *Day*, physician benefit from a referral relationship with an adjacent optical shop was challenged. The defendant physicians prescribed eyeglasses that were dispensed at a physically adjacent optical shop operated as a separate corporation which the physicians owned and controlled. Signage in the defendants' offices indicated the location of the adjacent shop, and the physical layout of the offices directed patients past the shop.

The trial court held that the circumstances created an unlawful "referral of patients" to the optical shop within the meaning of the statute, and entered a decree directing the defendant to divest itself of ownership of the optical shop, restraining the optical shop from filling any prescription for eyeglasses written by the defendant physicians as long as the physicians held a financial interest in the shop, and prohibiting the defendant physicians from referring patients to any optical shop in which they had a financial interest.

In affirming the trial court's findings, the Supreme Court found that the physicians' ownership interest in the optical dispensing company constituted compensation under the anti-rebating statute.⁶⁴ Further, the location of the optical company in relation to the physicians' offices and the signs directing patients past the optical company constituted "referrals" to the optical store under the statute.⁶⁵ The Court also affirmed the findings of a violation of the rebate statute, RCW 19.68.010, but modified the decree. The Court held that it was permissible for the defendant doctors to own stock in a dispensing optical shop, provided they did not attempt to refer patients to the shop, directly or indirectly, by sign, symbol, gesture, or physical arrangement of their offices.⁶⁶

ii. Wright v. Jeckle

In 2006 the Supreme Court issued its decision in *Wright v. Jeckle*,⁶⁷ the first reported decision interpreting 19.68 RCW in 37 years. In *Wright*, several patients filed a lawsuit against their physician, Dr. Milan Jeckle, who operated a medical clinic in the Spokane Valley.⁶⁸ Dr. Jeckle dispensed, at a profit, the prescription drug commonly known as "fen-phen" to patients seeking to lose weight.⁶⁹ The patients alleged that Dr. Jeckle violated the Consumer Protection Act (CPA), RCW 19.86.020, by engaging in "deceptive acts" in trade or commerce, and that he breached his fiduciary duty to them. The plaintiffs alleged that the alleged violation of RCW 19.68.010 were *per se* deceptive acts violative of the CPA.⁷⁰

In a unanimous opinion, the Court held that RCW 19.68.010 did not prohibit Dr. Jeckle from furnishing prescription diet drugs to his patients at a profit.⁷¹ The Court concluded that RCW 19.68.010 does not prevent a patient from paying a health care provider for services rendered or prescriptions received.⁷² The statute was found to not prevent a health care provider from making a profit on furnishing care or goods to patients.⁷³ Instead, when read in context, RCW 19.68.010 prohibits taking an "unearned ... profit" or "kickback" from a

⁶⁴ 76 Wn.2d at 418-19.

⁶⁵ *Id.* at 418.

⁶⁶ 76 Wn.2d at 420-21.

⁶⁷ 158 Wn.2d 375, 144 P.3d 301 (2006).

⁶⁸ *Id.* at 377.

⁶⁹ *Id.*

⁷⁰ *Id.* at 388.

⁷¹ *Id.* at 385.

⁷² *Id.* at 381.

⁷³ *Id.*

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third party.⁷⁴ The Court reasoned that the purpose of the anti-rebating law was not to prevent medical professionals from profiting from the goods and services that they provide, but to prevent kickbacks.⁷⁵ Thus, RCW 19.68.010 prohibits licensed practitioners from doing two things: paying anything of value in return for a referral, and receiving anything of value in return for referring patients (*i.e.*, making or receiving kickbacks).

iii. Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Associates, P.L.L.C.

Most recently, in *Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Associates, P.L.L.C.*,⁷⁶ the Supreme Court held that the anti-rebating statute exempts from its coverage profits earned by an employee of a firm that flow to the firm's owners, provided that the owners practice in the firm. Benton Franklin Orthopedic Associates (BFOA) is a physician-owned professional limited liability company in Kennewick, Washington, which, in addition to its orthopedic practice, employs several physical therapists who work in a facility separate from that occupied by the BFOA physicians. According to BFOA, the practice advises patients who require physical therapy services of BFOA's ownership interest in the physical therapy facility and provides a list of alternative physical therapy providers. Columbia Physical Therapy ("Columbia") is a professional services corporation owned by physical therapists that also employs physical therapists through several offices, including one in Kennewick. Columbia sued BFOA, alleging that BFOA violated the anti-rebate statute, as well as the corporate practice of medicine doctrine, the Professional Service Corporation Act (PSCA), and the Consumer Protection Act (CPA).

With regard to the anti-rebating statute, the Court distinguished BFOA's employment of physical therapists from the ophthalmologists' ownership interest in the optical dispensing company in *Day v. Inland Empire Optical*. Unlike in *Day*, where the ophthalmologists owned a *separate* entity that operated as an optical shop, BFOA's referring physician members provided professional services through the *same* firm as the physical therapists to which they referred patients. Because the physician-members of BFOA practiced as part of the same firm as the physical therapists, the profits from professional services rendered by employed physical therapists were not "unearned" and, therefore, were not barred by the anti-rebating statute.

24.3.2 State Medicaid False Statements/Fraud Provisions (Chapter 74.09 RCW)

Washington law prohibits attempting to induce referrals of, or making false statements related to, services reimbursed under the Medical Assistance (Medicaid) program.⁷⁷ While the language of this provision tracks the federal False Claims Act in some respects, it does not contain whistleblower provisions enabling private citizens to sue for violations in the name of the State.

The statute provides:

Any person, including any corporation, that

- (1) knowingly makes or causes to be made any false statement or representation of a material fact in any application for any payment under any medical care program authorized under this chapter, or
- (2) at any time knowingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to such payment, or knowingly falsifies, conceals, or

⁷⁴ *Id.*

⁷⁵ *Id.* at 382.

⁷⁶ --- P.3d ---, 2010 WL 964068 (Wash. Mar. 18, 2010).

⁷⁷ See Chapter 74.09 RCW.

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covers up by any trick, scheme, or device a material fact in connection with such application or payment, or

- (3) having knowledge of the occurrence of any event affecting (a) the initial or continued right to any payment, or (b) the initial or continued right to any such payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized,

shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.⁷⁸

In addition to the prohibitions against making false statements or representations, the statute prohibits providers from offering or receiving remuneration in return for the referral of Medicaid services. These provisions closely track the language of the federal Anti-kickback Law,⁷⁹ and provides as follows:

- (1) Any person, including any corporation, that solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
 - (a) in return for referring 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 under this chapter, or
 - (b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

- (2) Any person, including any corporation, that offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person
 - (a) to refer 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, under this chapter, or
 - (b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.⁸⁰

The statute was amended in 1995 to include prohibitions on physician referrals patterned after the federal Stark law, as follows:

- (3)
 - (a) Except as provided in 42 U.S.C. 1395nn, physicians are prohibited from self-referring any client eligible under this chapter for the following designated health services to a facility in

⁷⁸ RCW 74.09.230.

⁷⁹ 42 U.S.C. § 1320a-7b(a).

⁸⁰ RCW 74.09.240.

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which the physician or an immediate family member has a financial relationship:

- (i) clinical laboratory services;
 - (ii) physical therapy services;
 - (iii) occupational therapy services;
 - (iv) radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;
 - (v) durable medical equipment and supplies;
 - (vi) parenteral and enteral nutrients equipment and supplies;
 - (vii) prosthetics, orthotics, and prosthetic devices;
 - (viii) home health services;
 - (ix) outpatient prescription drugs;
 - (x) inpatient and outpatient hospital services;
 - (xi) radiation therapy services and supplies.
- (b) For purposes of this subsection, “financial relationship” means the relationship between a physician and an entity that includes either:
- (i) an ownership or investment interest; or
 - (ii) a compensation arrangement.
- For purposes of this subsection, “compensation arrangement” means an arrangement involving remuneration between a physician, or an immediate family member of a physician, and an entity.
- (c) The department is authorized to adopt by rule amendments to 42 U.S.C. 1395nn enacted after the effective date of this act.
- (d) This section shall not apply in any case covered by a general exception specified in 42 U.S.C. Sec. 1395nn.
- (4) Subsections (1) and (2) of this section shall not apply to
- (a) a discount or other reduction in price obtained by a provider of services or other entity under this chapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this chapter, and
 - (b) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

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- (5) Subsections (1) and (2) of this section, if applicable to the conduct involved, shall supersede the criminal provisions of chapter 19.68 RCW, but shall not preclude administrative proceedings authorized by chapter 19.68 RCW.⁸¹

The only reported opinion involving a claim under RCW 79.04.230 sheds little light upon the statute. In *State v. Quinn*,⁸² the defendant physician was charged with knowingly submitting false medical claims payable under the Medical Assistance program, as well as theft. The defendant allegedly engaged in double billing, submission of false diagnoses to assure payment, and submission of false claims for lab tests. The physician did not seriously contest the lawfulness of the alleged practices, but contended that the practices were those of his office staff acting on their own. A jury convicted him on 15 of 16 counts of submitting false claims, and two counts of theft.

On appeal, the physician challenged the convictions on various technical grounds involving jury instructions, evidentiary issues, and federal preemption. The Court of Appeals decision affirmed the convictions on all counts, but offered no nuanced interpretation of the meaning or import of the statute.

24.3.3 Health Care False Claims Act (Chapter 48.80 RCW)

Finally, Washington law broadly prohibits persons from making false claims related to health care with insurers, health maintenance organizations, health care service contractors and self-funded plans. The act prohibits persons from knowingly presenting false claims or making false statements related to claims for health care payment. In addition, the law prohibits persons from concealing or failing to disclose information in order to obtain health care payment.

The statute provides:

- (1) A person shall not make or present or cause to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false.
- (2) No person shall knowingly present to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Each claim that violates this subsection shall constitute a separate offense.
- (3) No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation.
- (4) No person shall conceal the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service. A person shall not conceal or fail to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.
- (5) No provider shall willfully collect or attempt to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payor to which the provider is a party.
- (6) A person who violates this section is guilty of a class C felony punishable under chapter 9A.20 RCW.
- (7) This section does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health

⁸¹ RCW 74.09.240.

⁸² 43 Wash. App. 696, 719 P.2d 936 (1986).

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maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees.⁸³

To date, there are no reported cases interpreting the scope or meaning of the statute.

⁸³ RCW 48.80.030.