CLARIFYING A POST-PAYMENT AUDIT FICTION: WHY INADEQUATE CLINICAL RECORDS ARE NOT A *PER SE* VIOLATION OF THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT

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"A bare assertion is not necessarily the naked truth."[1]

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[1] George Dennison Prentice (1802-1870), renowned journalist and editor of the *Louisville Daily Journal.*

I. Introduction

It usually starts rather innocently; a typical day at the office even. Shortly after lunch, the mail finally arrives and the receptionist eagerly begins to sort through a deluge of bills, product catalogs, and bothersome solicitations in order to find those envelopes emblazoned with an insurance company's name. You see, this is a relatively small chiropractic office; and, as is the case with the vast majority of outpatient medical practices, this chiropractor's income is almost exclusively dependent upon insurance reimbursement. Today, however, there is an envelope from one particular insurer that appears somewhat peculiar. It does not have the typical bulk and clear plastic address window that most explanation of benefit statements and insurance checks exhibit. Rather, this particular envelope is relatively light and eerily non-descript. Thinking nothing of it, the unwitting receptionist tears open the envelope. It takes only a split second for her to realize, though, that this is no boiler-plate coverage announcement. To the contrary, this pithy correspondence is from something called a "Special Investigations Unit." And, according to the letter, the insurer is conducting a "routine" retrospective claims audit and wants to review ten of the practice's patient records "to ensure accuracy in billing." Needless to say, this particular letter will soon find its way to the doctor's desk.

The above-described scenario may sound familiar to many licensed health care providers, particularly those practicing privately in New Jersey.[2] The significance of this all-too-subtle communication should not, however, be overlooked. The insurance carrier in question is, in no uncertain terms, announcing its intention to conduct a post payment audit[3] of the practice. The emotions that these notifications engender can vary from dismissive defiance to outright panic. While distress is certainly not warranted in most cases, simply tossing an audit notice in the trash is foolish at best, and can be disastrous at worst. After all, a post payment audit can lead to

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[2] For a multitude of reasons, which in and of themselves warrant a separate article, New Jersey has become the Bermuda Triangle of insurance audits.

[3] A "post payment audit" is a retroactive review of prior claims to evaluate whether or not payments were properly made under a health benefit plan. *See, e.g.*, GA. CODE ANN. § 33-20A-60 (2007) (A "postpayment audit" is "an investigation by a health benefit plan, carrier, or agent thereof regarding whether a claim was properly previously paid."). For purposes of this article, a health benefit plan is a "benefits plan [that] pays or provides hospital and medical expense benefits for [certain medical treatments], and is delivered or issued for delivery . . . by or through a [private insurance] carrier." N.J. STAT. ANN. § 17B:30-50 (2007).

a variety of uncomfortable, if not destructive, results including, but not limited to: exorbitant overpayment or refund requests; civil recoupment litigation; professional disciplinary proceedings; and insurance fraud prosecutions.

These post payment audits are, in most cases, conducted by a carrier's Special Investigations Unit ("SIU"), and they signal, in no uncertain terms, the start of an insurance fraud investigation.[4] In New Jersey, Special Investigations Units are the private insurance industry's first line of defense in rooting out and preventing insurance fraud; and providers who find themselves the subject of an SIU post payment audit are rarely randomly selected. Much like law enforcement, a private carrier will often receive a "tip" that leads to an investigation. These tips can be as benign as a patient calling a customer service line to question a particular treatment or charge. Or, in the alternative, a tip can be as incriminating as an anonymous call from an employee or former employee detailing an alleged impropriety. SIUs also depend upon a variety of complex statistical analyses and data mining reports to identify providers or practices that exhibit potentially problematic billing patterns. If a carrier communicates a desire to conduct a post payment audit, there is likely a reason for the request. It is, therefore, critical that providers understand their legal rights if they are audited.

A post payment audit can expose any number of billing inaccuracies, and thus expose a provider to a multitude of potential liabilities. For example, the most common error unearthed during these investigations is the inappropriate characterization of services on a claim submission.[5] Due to the strict time constraints for

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[4] *See* N.J. ADMIN. CODE § 11:16-6.4 (2007) (setting forth a requirement that all automobile insurers that issue more than 2,500 New Jersey automobile policies and health insurers that provide or administer medical benefits to more than 10,000 persons must establish a full-time Special Investigations Unit to, among other things, conduct "investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that" a false or fraudulent claim has been submitted).

[5] Notably, health care providers and insurance carriers across the country "speak the same language." The Administrative Simplification Act ("ASA"), which was enacted as part of the Health Insurance Portability and Accountability Act ("HIPAA"), Pub. L. No. 104-191, established uniform standards to enable the electronic interchange of protected health information between health care providers and insurers, and directed the Secretary of the Department of Health and Human Services to select code sets for appropriate data elements relating to the electronic transactions. 42 U.S.C. § 1320d-2(c)(1)(A) (2007). Pursuant to the HIPAA Transaction and Code Set regulations, claims submissions are to be coded

processing and paying claims submissions,[6] insurers are forced to consider most claims submissions without conducting any review of the corresponding treatment records. As a result, insurance claims submitted on behalf of a patient under a health benefits plan are processed in good faith. Insurers will assume that the diagnosis and procedure codes listed on a provider's claim submission are correct and they will process the claim for payment as long as there is not any other facial deficiency.[7] When these claims are reviewed years later, it should not come as a shock that errors are often uncovered. These problems can range from a reasonable mistake, like improper code selection, to the nefarious, such as billing for services that were never provided or purposely misrepresenting the nature of services actually rendered. Obviously, a provider's rights at the completion of an audit will vary considerably based upon what, if anything, is unearthed by the auditor.

This article is about the rights and remedies that are available to providers when one very discrete issue arises. Because a review of the corresponding treatment records is the first logical step in any audit, insufficient clinical documentation can be a red flag for the auditors. That said, special investigators rarely, if ever, limit their data collection to medical records. Indeed, a review of a provider's treatment records will typically be accompanied by: (1) a direct inspection of the provider's physical location, including any devices or machines utilized in the treatment of the audited patients; (2) the review of additional documentary evidence such as sign-in sheets, employee handbooks, or procedure manuals; and (3) the gathering

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using the American Medical Association ("AMA") Current Procedural Terminology ("CPT") codes and the Health Care Common Procedure Coding System ("HCPCS"), which was established by the Centers for Medicare and Medicaid Services ("CMS") and primarily represents items, supplies, and non physician services not covered by a CPT code. 45 C.F.R. § 162.925(c)(1) (2007) (requiring health plans to accept and promptly process standard transactions containing the restricted code sets as defined in Subpart J of the regulation); and 45 C.F.R. § 162.1002(e)(1) (defining CPT codes and HCPCS codes submitted for physician services as the only available code set). Unfortunately, these code sets are understandably complex, and the misuse of a code to describe a particular treatment or service is the most common error identified during a post payment audit. This problem is exacerbated by anecdotal evidence that shows health care providers are often susceptible to bad coding advice from colleagues, consultants, or medical device manufacturers.

[6] *See* N.J. STAT. ANN. §§ 17B:26-9.1, :27-44.2 (2007) (the "Prompt Pay Laws").

[7] "Facial deficiencies" include, but are not limited to: a conflict in appropriately linking the diagnosis, as represented by the International Classification of Diseases ("ICD-9") codes, or diagnostic codes, to the procedure, as represented by CPT or HCPCS procedure codes, reported on the claim submission; the exhaustion or termination of the relevant patient's allotted benefits; or issues related to secondary insurance or the coordination of benefits.

of testimonial evidence, such as interviewing the provider and employees, or surveying patients.[8] The issue discussed herein, however, is the legal rights of providers if, even after this exhaustive investigatory process, the sole error the post payment audit exposes is poor recordkeeping.

Insufficient clinical documentation can mean a number of things depending on the particular circumstances of each case. For example, many providers are contractually obliged to record a specific amount of information in order to be eligible for reimbursement as a "participating provider."[9] It follows, therefore, that the failure to adequately document certain treatments or services may entitle an insurance carrier to a refund based upon the participating provider's breach of contract. As such, most licensed health care providers are obligated to meet a recordkeeping standard[10] that is promulgated by the respective licensing boards. Thus, the failure to keep adequate clinical records will, in most cases, subject a provider to professional disciplinary sanctions. The question that has yet to be definitively answered by any court in this state is whether or not the failure to keep "adequate" clinical records is, in and of itself, insurance fraud. As illogical or unfair as such an

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[8] *See* U.S. DEP'T OF HEALTH AND HUMAN SERV., OFF. OF INSP. GEN., OFF. OF AUDIT SERV., THE AUDIT PROCESS 15-17 (2005), http://oig.hhs.gov/organization/OAS/OIGAuditProcess.pdf (describing the data collection and analysis phase of government audits).

[9] Generally speaking, a "participating provider" refers to a health care provider that has entered into a contract, or a "participating provider agreement," with an insurer. "Typically, this contractual relationship entails the provider agreeing to provide the insurance company's covered patients a substantial discount below their regularly-charged rates. This will be mutually beneficial in theory, as the insurer will be billed at a reduced rate when its insureds utilize the services of the 'preferred' provider and the provider will see an increase in its business as almost all insureds in the [plan] will use only providers who are members. Even the insured should benefit, as lower costs to the insurer should result in lower rates . . . in premiums." Wikipedia.org, Preferred Provider Organization ("PPO"), http://en.wikipedia.org/wiki/Preferred_provider_organization (last visited Apr. 13, 2007).

[10] *See, e.g.*, N.J. ADMIN. CODE § 13:35-6.5 (2007) (setting forth the recordkeeping requirements of the New Jersey Board of Medical Examiners); N.J. ADMIN. CODE § 13:30-8.7 (setting forth the recordkeeping requirements of the New Jersey Board of Dentistry); N.J. ADMIN. CODE § 13:38-2.3 (setting forth the recordkeeping requirements of the New Jersey Board of Optometry); N.J. ADMIN. CODE § 13:44E-2.2 (setting forth the recordkeeping requirements of the New Jersey Board of Chiropractic Examiners); N.J. ADMIN. CODE § 13:39A-3.1 (setting forth the recordkeeping requirements of the New Jersey Board of Physical Therapy); N.J. ADMIN. CODE § 13:44K-10.1 (setting forth the recordkeeping requirements of the New Jersey Board of Occupational Therapy); N.J. ADMIN. CODE § 13:42-8.1 (setting forth the recordkeeping requirements of the New Jersey Board of Psychological Examiners).

inferential leap sounds, this is an actual theory of recovery that private insurance carriers are increasingly advancing.

This article argues that insufficient clinical records are not, in the absence of any further corroborating evidence, tantamount to insurance fraud. Section II of the article sheds further light on the post payment audit phenomena. Specifically, this section discusses where post payment audits come from and why there has recently been a rise in their usage in New Jersey. Section III of the article discusses why distinguishing between fraudulent conduct and less culpable malfeasance is so significant under New Jersey law. In particular, this section sets forth the new statutory framework governing health insurance reimbursement in New Jersey. It also describes precisely why the mere allegation of fraud drastically changes the rights and remedies available to a provider facing adverse post payment audit findings. Section IV of this article breaks down notable cases interpreting the New Jersey Insurance Fraud Prevention Act ("IFPA").[11] This section addresses the vast judicial expansion of the IFPA, while at the same time factually distinguishing each case from our hypothetical: the case of a provider who has done nothing wrong aside from keeping sloppy or incomplete clinical records. Finally, the article concludes with a brief discussion of the policy rationale justifying a clear distinction between administrative negligence and abject fraud, and sets forth a potential legislative proposal that would effectively ensure that fraud suits become the exception, not the rule.

II. The Purpose, Legal Basis, and Recent Proliferation of Private Insurance Carrier-Initiated Post-Payment Audits in New Jersey

According to the Center for Medicare and Medicaid Services ("CMS"), health care expenditures in the United States rose to just under two trillion dollars in 2005, or about sixteen percent of the nation's Gross Domestic Product ("GDP").[12] As healthcare costs continue to increase for all Americans, this figure is, not surprisingly, on the rise. Indeed, CMS also projects that "[b]y 2016, health care spending in the United States [will] reach just over $4.1 trillion and

[11] N.J. STAT. ANN. § 17:33-1 to -30.

[12] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTER FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURE PROJECTIONS: 2006-2016, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf (last visited Apr. 13, 2007).

comprise 19.6 percent of GDP."[13] Based upon the sheer magnitude of healthcare spending in this country, particularly as it relates to the overall size of the domestic economy, it is incumbent upon all healthcare delivery systems, both public and private, to ensure that healthcare dollars are doled out appropriately and in an efficient manner.

Unfortunately, these goals are not being met by the industry. The National Healthcare Anti-Fraud Association estimates that "of the nation's annual health care outlay, at least [three] percent . . . is lost to outright fraud."[14] "Other estimates by government and law enforcement agencies place the loss as high as [ten] percent of [the nation's] annual expenditure . . . each year."[15] For example, in November 2005, CMS reported that the Medicare program made an estimated twelve billion dollars in improper payments.[16] It is even more alarming that the very people we entrust with oversight over our healthcare decisions and needs are apparently the real root of the problem. According to the Coalition Against Insurance Fraud, eighty percent of health care fraud is directly attributable to health care providers.[17] It follows, therefore, that continued and increased vigilance is required in the detection and prevention of provider-based insurance fraud.

The Federal government has recognized that post payment audits are an essential tool in combating healthcare fraud and abuse.[18] To address Medicare's apparent vulnerability, Congress enacted a provision in the Health Insurance Portability and

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[13] *Id.*

[14] National Healthcare Anti-Fraud Association, About Healthcare Fraud: A Serious and Costly Reality For All Americans, http://www.nhcaa.org/eweb/dynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud (last visited Feb. 24, 2008).

[15] *Id.*; *see also* U.S. GEN. ACCT. OFF., REP. NO. GAO/HRD-92-69, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS, COMMITTEE ON GOVERNMENT OPERATIONS, HOUSE OF REPRESENTATIVES, HEALTH INSURANCE: VULNERABLE PAYERS LOSE BILLIONS TO FRAUD AND ABUSE 1 (May 7, 1992), *available at* http://archive.gao.gov/t2pbat6/146547.pdf ("Estimates vary widely on the losses resulting from fraud and abuse, but the most common is 10 percent . . . of our total health care spending.").

[16] U.S. GOV'T ACCOUNTABILITY OFF., REP. NO. GAO-06-813, REPORT TO THE CHAIRMAN, COMMITTEE ON FINANCE, U.S. SENATE, MEDICARE INTEGRITY PROGRAM: AGENCY APPROACH FOR ALLOCATING FUNDS SHOULD BE REVISED 1 (Sept. 2006), *available at* http://www.gao.gov/new.items/d06813.pdf [hereinafter "GAO 9/06 Report"].

[17] Coalition Against Insurance Fraud, By the Numbers: Fraud Stats, http://www.insurancefraud.org/stats.htm (last visited Apr. 13, 2007).

[18] *See* 42 U.S.C. § 1395ddd(f)(7) (2007) (setting forth the statutory requirements for conducting a post payment audit of a provider or supplier of services under the Medicare Integrity Program).

Accountability Act of 1996 ("HIPAA")[19] that established the Medicare Integrity Program ("MIP").[20] The MIP provides funds to CMS to safeguard the more than $300 billion in program payments made to health care service providers and health care equipment suppliers on behalf of its beneficiaries. Specifically, the "MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse."[21] To achieve this statutory mandate, CMS, through third-party administrators, conducts five program integrity activities:

> (1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS; (2) medical reviews of claims to determine whether services provided are medically reasonable and necessary; (3) determinations of whether Medicare or other insurance sources have primary responsibility for payment, which is called secondary payer; (4) identification and investigation of potential fraud cases, which is called benefit integrity; and (5) education to inform providers about appropriate billing procedures.[22]

It is in the context of the second item, "medical reviews of claims to determine whether services provided are medically reasonable and necessary," that post payment audits are specifically authorized under the MIP.[23] Between 1997 and 2005, the amount of money allocated by the MIP for these medical reviews rose from $118.6 million to $165.9 million.[24] This increase in available funds has invariably led to an increase in the number of post payment audits conducted through the MIP by Medicare third-party administrators.

Due to the long and sordid history of insurance fraud within the state, it is not surprising that New Jersey has taken a relatively proactive approach to combating insurance fraud. In 1983, thirteen years before the advent of the MIP, the state legislature enacted the IFPA.[25] The IFPA is a "comprehensive statute designed to help remedy high insurance premiums [that] the Legislature deemed to

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[19] HIPAA, *supra* note 5.

[20] 42 U.S.C. § 1395ddd(a) ("There is hereby established the Medicare Integrity Program . . . under which the Secretary shall promote the integrity of the Medicare program.").

[21] GAO 9/06 Report, *supra* note 16, at 1.

[22] *Id.* at 2.

[23] 42 U.S.C. § 1395ddd(f)(7) (authorizing the use of "payment audits" and describing the statutory requirements for conducting a post payment audit, including notice, explanation, and "probe sampling").

[24] GAO 9/06 Report, *supra* note 16, at 13.

[25] N.J. STAT. ANN. § 17:33-1-30 (2007).

be a significant problem."[26] The New Jersey legislature's stated purpose in enacting the IFPA:

> was to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.[27]

The current manner in which the Act seeks to achieve these crucial goals as it relates to the permitted activities of private insurance companies[28] is two-fold. First, the Act, as amended in both 1993 and 1998, requires every "insurer writing health insurance or private passenger automobile insurance in this State shall file with the [Department of Banking and Insurance] a plan for the prevention and detection of fraudulent insurance applications and claims."[29] It is this provision that spurred the creation of private carrier SIUs.[30] More importantly, it is by and through these "Fraud Prevention Plans" that most private insurance carriers receive the express consent[31] of the Department of Banking and Insurance to conduct post payment audits, much in the same way as contemplated under the MIP. Second, the IFPA enables any "insurance company damaged as a result of a violation of this act" to file a lawsuit "in any court of competent jurisdiction to recover compensatory damages, which shall include reasonable investigation expenses, costs of suit

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[26] Allstate N.J. Ins. Co. v. Cherry Hill Pain & Rehab Inst., 911 A.2d 493, 599 (N.J. Super. Ct. App. Div. 2006); State v. Sailor, 810 A.2d 564, 566 (N.J. Super. Ct. App. Div. 2001) ("[T]he [IFPA] is a comprehensive statute designed to help remedy high insurance premiums[,] which the [l]egislature deemed to be a significant problem.").

[27] Liberty Mut. Ins. Co. v. Land, 892 A.2d 1240, 1245 (N.J. 2006); N.J. STAT. ANN. § 17:33-2.

[28] For purposes of this article, the statutorily mandated and/or authorized fraud prevention and detection activities of private insurance carriers are stressed due to subject matter relevance. It is noteworthy, however, that subsequent amendments to the IFPA also: (1) established the Office of the Insurance Fraud Prosecutor, N.J. STAT. ANN. § 17:33A-16; (2) called for the establishment of a statewide fraud enforcement policy, N.J. STAT. ANN. § 17:33A-20; and (3) established standards for the Fraud Investigatory Section of the Department of Banking and Insurance, N.J. STAT. ANN. § 17:33A-21.

[29] N.J. STAT. ANN. § 17:33A-15.

[30] N.J. ADMIN. CODE § 11:16-6.4 (2007)

[31] N.J. STAT. ANN. § 17:33A-15(a) ("The plan shall be deemed approved by the commissioner if not affirmatively approved or disapproved by the commissioner within 90 days of the date of filing.").

and attorneys fees."[32] Moreover, if an insurance company can demonstrate that a violator has engaged in a pattern of fraudulent claims, it can recover treble damages.[33] Taken cumulatively, these provisions explicitly vest private insurance carriers with broad authority to conduct post payment audits as a fraud prevention mechanism, and to thereafter recover misappropriated claim payments.

As to why there appears to be a marked increase in the number of post payment audits being conducted in New Jersey, the answer is quite simple: the activities of these SIUs have been overwhelmingly successful. While state-specific statistics are somewhat difficult to come by, SIUs are effectively utilized by insurance carriers throughout the country. For example, in 2004 alone, The Blue Cross Blue Shield Association reported that the SIU anti-fraud activities of its thirty-nine independent, locally operated Blue Cross Blue Shield Entities "resulted in savings and recoveries of nearly $228 million."[34] This number is particularly impressive when compared to the amount of money allocated to fund fraud prevention and detection activities. Indeed, as far back as 1998, the Coalition Against Insurance Fraud reported that insurance carriers were recovering eleven dollars in misappropriated funds for every dollar spent on "fighting fraud."[35] It is a relative certainty that with increased carrier vigilance this number has risen drastically over the past nine years. The efficacy of these investigative programs is also bolstered by one exceptionally obvious fact: most licensed healthcare providers simply do not understand their rights when faced with any claim denial, let alone a retroactive denial of hundreds, or possibly even thousands, of claims.

III. The Health Claims Authorization, Processing, and Payment Act: How "Fraud" Became the Pot of Gold at the End of the Rainbow in New Jersey

In recent years, the utilization management[36] policies by which

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[32] N.J. STAT. ANN. § 17:33A-7.

[33] N.J. STAT. ANN. § 17:33A-7(b) ("A successful claimant under subsection a. shall recover treble damages if the court determines that the defendant has engaged in a pattern of violating this act.").

[34] Blue Cross Blue Shield Association, Anti-Fraud Initiatives, http://www.bcbs.com/news/press/facts/anti-fraud.html (last visited Apr. 14, 2007).

[35] Coalition Against Insurance Fraud, *supra* note 17.

[36] Under New Jersey law, utilization management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified

private insurance carriers[37] deny, reduce, or terminate patient benefits have increasingly frustrated licensed health care providers ("providers") throughout New Jersey. Indeed, providers that submit claims to carriers on behalf of their patients often find themselves subjected to two very unsettling circumstances. First and foremost, claim denials from most carriers are rarely accompanied by anything more than a generic denial code or boilerplate language that fails to adequately explain the particular deficiencies of the submitted claim. Second, and perhaps even more alarming, once a claim is submitted, processed, and paid, carriers now routinely conduct post payment audits, the express purpose of which is to recoup previously-paid benefits. Unfortunately, both of these situations are exacerbated by the confusion that exists among providers as to what rights and remedies they may have when faced with either an initial or retrospective claim denial.

As a by-product of the New Jersey legislature's acknowledgement of this uncertainty, the Health Claims Authorization, Processing and Payment Act[38] ("HCAPPA")—signed into law by Governor Codey on

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> guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

N.J. STAT. ANN. § 17B:30-50 (internal quotations omitted).

[37] For purposes of this article, "private insurance carrier" means "an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans" in New Jersey. *Id.* By way of further clarification: "covered service means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services"; and "covered person means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan." *Id.* (internal quotations omitted).

[38] N.J. STAT. ANN. § 17B:30-48–54, which was enacted as part and parcel of Pub. L. 2005, c.352, established "uniform procedures and guidelines for hospitals, physicians and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers." N.J. STAT. ANN. § 17B:30-49(d). In addition, Pub. L. 2005, c.352, also amends and supplements various previously enacted statutes, including portions of: the Health Care Quality Act, N.J. STAT. ANN. § 26:2S-11 to 12; the Hospital Service Corporation Act, N.J. STAT. ANN. § 17:48-8.4; the Medical Service Corporation Act, N.J. STAT. ANN. § 17:48A-7.12; the Health Service Corporation Act, N.J. STAT. ANN. § 17:48E-10.1; the Prompt Pay Laws, N.J. STAT. ANN. §§ 17B:26-9.1, :27-44.2; the Health Maintenance Organization Act, N.J. STAT. ANN. § 26:2J-8.1; and the Prepaid Prescription Services Organization Act, N.J. STAT. ANN. § 17:48F-13.1.

January 12, 2006, and effective 180 days therefrom—establishes "uniform procedures and guidelines" that insurance carriers must follow when making, communicating, and reconsidering utilization management decisions.[39] As a threshold matter, the HCAPPA requires carriers to publish their utilization management and claims processing policies on the Internet in a "clear and conspicuous manner."[40] This information must include: relevant clinical criteria guidelines, whether drafted internally or adopted from a commercial source; billing, coding, and documentation standards; and any further information that the Commissioner of Banking and Insurance deems necessary. Furthermore, the statute requires carriers to post any changes to these policies at least thirty calendar days prior to their proposed effective date. But, the HCAPPA's significance goes far beyond demystifying utilization management.

In addition to shedding some much-needed light upon the manner and standards by which carriers review claims, the HCAPPA fundamentally alters the rights and remedies available to those providers who wish to dispute a carrier's utilization management decisions. First, the statute sets forth strict requirements as to how quickly a carrier must respond to a provider's request for prior authorization of services. For care rendered in an outpatient setting,

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[39] Because it is fair and reasonable for hospitals and physicians to receive reimbursement for health care services delivered to covered persons under their health benefits plans and inefficiencies in any area of the health care delivery system reflect poorly on all aspects of the health care delivery system, and because those inefficiencies can harm the consumers of health care, it is appropriate for the Legislature now to establish uniform procedures and guidelines for hospitals, physicians and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers.

N.J. STAT. ANN. § 17B:30-49(d).

[40] A payer shall provide the following information concerning utilization management and the processing and payment of claims in a clear and conspicuous manner through an Internet website no later than 30 calendar days before the information or policies or any changes in the information or policies take effect: (1) a description of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of health care services; (2) a list of the material, documents or other information required to be submitted to the payer with a claim for payment for health care services; (3) a description of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description; (4) the payer's policy or procedure for reducing the payment for a duplicate or subsequent service provided by a health care provider on the same date of service; and (5) any other information the commissioner deems necessary.

N.J. STAT. ANN. § 17B:30-51(a).

such as a physician or group practice, a carrier must respond to a request for prior authorization within fifteen days, or the care is deemed approved.[41] If a request for prior authorization is approved, either expressly or through a carrier's failure to timely respond to an authorization request, the carrier cannot subsequently deny reimbursement for that service in the absence of fraud or misrepresentation.[42] Second, the statute provides licensed health care providers with access to the Independent Health Care Appeals Program[43] to dispute adverse coverage decisions on behalf of their patients.[44] This program gives providers an avenue to challenge a carrier's findings relative to the medical necessity of a denied service

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[41] [I]n the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or physician within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made.

N.J. STAT. ANN. § 17B:30-52(a)(3).

> If a payer fails to respond to an authorization request within the time frames established pursuant to subsection a. of this section, the hospital or physician's request shall be deemed approved and the payer shall be responsible to the hospital or physician for the payment of the covered services delivered pursuant to the hospital or physician's contract with the payer.

N.J. STAT. ANN. § 17B:30-52(c).

[42] [N]o payer, or payer's agent, shall deny reimbursement to a hospital or physician for covered services rendered to a covered person on grounds of medical necessity in the absence of fraud or misrepresentation if the hospital or physician . . . requested authorization from the payer and received approval for the health care services delivered prior to rendering the service.

N.J. STAT. ANN. § 17B:30-52(a).

[43] The "Independent Health Care Appeals Program" was created as part and parcel of the Health Care Quality Act, Pub. L. 1997, c.192 (codified at N.J. STAT. ANN. § 26:2S-11 to -16.).

[44] The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person *or any health care provider acting on behalf of the covered person* but only with the covered person's consent. The appeal review shall not include any decisions regarding benefits not covered by the covered person's health benefits plan.

N.J. STAT. ANN. § 26:2S-11 (emphasis added); *cf.* Pub. L. 1997, c. 192 , which states:

> The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person. The appeal review shall not include any decisions regarding benefits not covered by the covered person's health benefits plan.

or treatment.[45] As an added incentive for providers to appeal adverse coverage determinations on behalf of their patients, the statute mandates that all costs associated with this independent clinical review, aside from a nominal filing fee of twenty-five dollars, are to be borne by the carrier.[46]

While the foregoing amendments to the procedural and substantive rights of patients under the care of a licensed health care provider cannot be underestimated, the accompanying amendments to various other portions of New Jersey law offered, at least in theory, a profound benefit to licensed health care providers in the context of the post payment audits described in Section II. Indeed, shortly after then-Governor Cody signed the HCAAPA into law last January, legal pundits throughout the state, including this author, hailed the statute as a long-overdue equalizer in the continued proliferation of private insurance carrier initiated post payment audits.[47] Specifically, the statute contains three provisions that, at least facially, substantially alter the manner in which a carrier may conduct these retrospective audits. First, the statute seeks to limit the "look-back" period in most post payment audits to eighteen months.[48] Second, the statute

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[45] Coverage disputes that are subject to the Independent Health Care Appeal Programs center on those services or treatments for which a carrier denies coverage due to an alleged lack of medical necessity.

> Medical necessity or medically necessary means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

N.J. STAT. ANN. § 17B:30-50 (internal quotations omitted).

[46] N.J. STAT. ANN. § 26:2S-12(h) ("The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the [Department of Banking and Insurance].").

[47] John W. Leardi, *Assessing the Health Claims Authorization, Processing and Payment Act: The New Jersey Legislature Finally Levels the Playing Field*, New Jersey Chiropractor, Mar. 2006, at 1.

[48] With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made.

appears to significantly limit the circumstances under which a carrier could make an overpayment demand based upon statistical extrapolation.[49] Finally, the statute requires all carriers to establish an internal appeal mechanism to reconsider disputed overpayments and creates a binding arbitration system to resolve overpayment disputes that persist.[50] Unfortunately, a little less than a year after the statute finally took effect,[51] it has become painfully obvious that its numerous loopholes are problematic, to say the least. As a result, a number of insurance carriers have begun to artfully frame their investigations so as to avoid compliance with the provider-friendly portions of the statute, while simultaneously taking full advantage of the new law's most ominous feature—its explicit sanctioning of offsetting an overpayment demand against a provider's current claims submissions.[52]

As a threshold issue, limiting a carrier's audit of previously paid

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N.J. STAT. ANN. § 17:48-8.4(d)(10); *accord* § 17:48A-7.12(d)(10); § 17:48E-10.1(d)(10); § 17B:26-9.1(d)(10); § 17B:27-44.2(d)(10); § 26:2J-8.1(d)(10); § 17:48F-13.1(d)(10).

[49] No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances: (a) in judicial or quasi-judicial proceedings, including arbitration; (b) in administrative proceedings; (c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or (d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan . . . and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor.

N.J. STAT. ANN. § 17:48-8.4(d)(10); *accord* § 17:48A-7.12(d)(10); § 17:48E-10.1(d)(10); § 17B:26-9.1(d)(10); § 17B:27-44.2(d)(10); § 26:2J-8.1(d)(10); § 17:48F-13.1(d)(10).

[50] "Any dispute regarding the determination of an internal appeal ... may be referred to arbitration as provided in this paragraph." N.J. STAT. ANN. § 17:48-8.4(e)(2); *accord* § 17:48A-7.12(e)(2); § 17:48E-10.1(e)(2); § 17B:26-9.1(e)(2); § 17B:27-44.2(e)(2); § 26:2J-8.1(e)(2); § 17:48F-13.1(e)(2).

[51] Section 22 of L. 2005, c. 352 provides: "This act shall take effect on the 180th day after enactment, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act." L. 2005, c. 352 was approved on January 12, 2006.

[52] If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor . . . the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

N.J. STAT. ANN. § 17:48-8.4(d)(11)(b); *accord* § 17:48A-7.12(d)(11)(b); § 17:48E-10.1(d)(11)(b); § 17B:26-9.1(d)(11)(b); § 17B:27-44.2(d)(11)(b); § 26:2J-8.1(d)(11)(b); § 17:48F-13.1(d)(11)(b).

claims to eighteen months—as opposed to six years—has its advantages, particularly for those providers whose coding and documentation is continually improving. This portion of the new statute is tempered, however, by language that expressly exempts cases involving "fraud" or a "pattern of inappropriate billing."[53] But because the statute fails to precisely articulate what type of malfeasance amounts to a "pattern" of inappropriate billing, and because the statute does not set forth any gateway evidentiary standard for a carrier to assert a fraud allegation, the eighteen-month statute of limitations is completely ineffective. In the face of this substantial ambiguity, many carriers continue to audit more than eighteen months worth of claims.

Similarly, the new law's apparent limitation on statistical extrapolation has proven to be somewhat toothless. The statute limits the situations in which a carrier can extrapolate its sample findings over a larger audit population to: (1) judicial or quasi-judicial proceedings, such as arbitration; (2) audits where there are altered, reconstructed, or a "material" number of missing patient records; and (3) instances of fraud, *after* the matter has been referred to the Office of the Insurance Fraud Prosecutor ("OIFP").[54] While the first two exceptions are relatively straightforward, the third has proven enigmatic. Once again, the statute's failure to require anything more than a carrier's mere suspicion of fraud—even if that suspicion is completely unfounded—emasculates this provision. In reality, extrapolation is still being used across the board, even in those cases where a carrier's fraud allegation is whimsical at best.

Likewise, the internal appellate rights and the binding arbitration system created by the statute,[55] both of which are presumably aimed at efficiently resolving non-clinical overpayment disputes,[56] are tempered by accompanying provisions that vest carriers with unprecedented authority to recapture disputed funds without giving providers a chance to voice any objection. The new

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[53] *See supra* note 48.

[54] *See supra* note 49.

[55] N.J. STAT. ANN. § 17:48-8.4(e)(2) ("No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to [N.J. STAT. ANN. § 26:2S-11] shall be the subject of arbitration pursuant to this subsection."); *accord* § 17:48A-7.12(e)(2); § 17:48E-10.1(e)(2); § 17B:26-9.1(e)(2); § 17B:27-44.2(e)(2); § 26:2J-8.1(e)(2); § 17:48F-13.1(e)(2).

[56] "Any dispute regarding the determination of an internal appeal . . . may be referred to arbitration as provided in this paragraph." N.J. STAT. ANN. § 17:48-8.4(e)(2); *accord* § 17:48A-7.12(e)(2); § 17:48E-10.1(e)(2); § 17B:26-9.1(e)(2); § 17B:27-44.2(e)(2); § 26:2J-8.1(e)(2); § 17:48F-13.1(e)(2).

law allows carriers to assess an overpayment demand against payments for future claims submissions when all of a provider's appeal and arbitration rights have been exhausted *or* if the carrier determines that the overpayment is a result of fraud and refers the case to the OIFP.[57] Yet again, the statute does not require a carrier to substantiate its fraud allegation, so even the most implausible suspicion forecloses a provider's right to appeal, let alone arbitrate, an overpayment demand before funds are recaptured. In essence, the statute grants carriers the unfettered right to serve as the judge, jury, and executioner.

In hindsight, the cumulative effect of these statutory carve-outs for fraud should not have been entirely unexpected. Indeed, while a number of private carriers have altered their auditing and overpayment recovery practices in light of the new statute, the vast majority have instead taken one of two alarming positions. First, many carriers have decided that because their post payment audits are conducted by an SIU charged with investigating fraud,[58] the new statute simply does not apply to the post payment audit policies and procedures promulgated and enforced by these units. While the sheer absurdity of this position is self-evident,[59] the second tactic increasingly used in private-carrier recoupment efforts is far more nefarious; in making overpayment demands, carriers are raising the specter of fraud, regardless of whether or not such an assertion is actually supported by the facts unearthed during a particular investigation. While certain billing and coding inaccuracies do not, in and of themselves, constitute fraud,[60] the most problematic

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[57] *See supra* note 52.

[58] N.J. ADMIN. CODE § 11:16-6.4 (2007) (mandating that each private insurance carrier's creation of an SIU and describing a stated responsibility of an SIU as "[c]onducting investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that a violation of [the New Jersey Insurance Fraud Prevention Act] has occurred").

[59] As discussed in the Introduction, *see supra* note 3, the purpose of a post payment audit is to conduct a retrospective review of previously submitted claims under a health benefit plan to ensure accuracy in claims payments. While fraud detection and prevention is a necessary outgrowth of audit activities, there is a wealth of less culpable offenses that may just as easily give rise to a legitimate overpayment demand. These include, but are not limited to, negligent code selection or the violation of a contractual requirement.

[60] "A common legal definition of fraud is an intentional misrepresentation, concealment, or nondisclosure for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or to surrender a legal right." Mikes v. Straus, 274 F.3d 687, 696 (2d Cir. 2001) (quoting WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 904 (1981)). Notably, however, in order to state a claim

manifestation of this approach is to cite inadequate clinical documentation as *per se* evidence of a fraudulent claim actionable under the IFPA, and thus as a basis to deny an audited provider the statutory rights created under the new law.

IV. Considering "Inadequate" Clinical Records under Caselaw that Broadly Construes the New Jersey Insurance Fraud Prevention Act

The IFPA has been interpreted extremely broadly by New Jersey courts, undoubtedly in recognition of the state's strong policy interest in rooting out insurance fraud.[61] In fact, as is detailed more fully below, there are numerous cases standing for the proposition that the failure of a provider to adhere to certain requirements of his or her licensing regulations constitutes fraud. Moreover, a provider's repeated submission of claims, while in violation of these same provisions, has been similarly held to constitute a pattern of fraudulent billing thus entitling the aggrieved insurance carrier to treble damages under the IFPA. Not surprisingly, many insurance carriers have cited the cases that follow as standing for the proposition that provider compliance with *all* statutory and administrative regulations is a prerequisite to bill or collect fees for treatment. This position, however, misstates the scope and context of caselaw interpreting the relevance of licensing regulations under the IFPA.[62] Indeed, not a single reported case in New Jersey sanctions the inferential leap required to conclude that a failure to maintain *adequate* patient records is tantamount to fraudulent conduct.

The seminal New Jersey case on the effect of licensing regulations on the eligibility to receive insurance benefits, *Allstate Ins.*

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for statutory fraud under the IFPA, a carrier need only allege facts that show that the defendant "knowingly misrepresented or failed to disclose facts material to the claims submitted to [the insurance carrier] for reimbursement. Aetna v. Carabasi, 2006 WL 66460 at *2 (N.J. Super. Ct. App. Div. 2006).

[61] *Allstate N.J. Ins. Co.*, 911 A.2d at 500 (N.J. Super. Ct. App. Div. 2006) (quoting Varano, Damian & Finkel, L.L.C. v. Allstate Ins. Co., 840 A.2d 262, 266 (N.J. Super. Ct. App. Div. 2004) ("There is a strong public policy in this State to root out insurance fraud.")).

[62] Significantly, each and every case discussing professional license requirements as they relate to the IFPA was decided in the context of personal injury benefits under the Automobile Insurance Cost Reduction Act (the "AICRA"), N.J. STAT. ANN. § 39A:6A-1 to -35. Nonetheless, carriers have widely interpreted these cases as controlling in all IFPA cases, presumable under the assumption that a court would draw an analogy between a provider's eligibility to receive benefit payments under an automobile policy and a health benefits plan.

Co. v. Orthopedic Evaluations, Inc. ("*OEI*"),[63] held that "any healthcare service authorized by [the Automobile Insurance Cost Reduction Act ("AICRA")], in order to be eligible for recognition, must comply with any other significant qualifying requirements of law *that bear upon rendition of the service.*"[64] In *OEI*, the alleged non-compliance involved a medical diagnostic testing facility that did not meet certain regulatory requirements; specifically, standards promulgated by the Board of Medical Examiners that required that the facility be owned and controlled by a plenary licensed physician.[65] In its decision, the Appellate Division concluded that the regulation requiring that plenary licensed physicians exercise dominion and control over the day-to-day operations bore directly upon the defendant facility's rendition of services; the threat of non-licensed individuals engaging in the unauthorized practice of medicine presents a direct threat to the safety and welfare of the public-at-large.[66] Notably, the court in *OEI* never went so far as to call this disqualification from receiving personal injury benefits under the AICRA a violation of the IFPA; nevertheless, this broadening of the *OEI* rule would soon follow.

In *Allstate Ins. Co. v. Schick*,[67] the court denied the defendant's motion for summary judgment, holding that:

> [t]he foregoing evidence, as well as the additional information and documents set forth in Allstate's appendices, at least raises factual issues to support Allstate's contention that the alleged ownership of [two diagnostic testing facilities] by plenary licensed physicians is merely a sham designed to circumvent the administrative regulations set forth in [N.J. ADMIN. CODE §] 13:35-2.5, requiring that diagnostic facilities be owned by plenary licensed physicians.[68]

More importantly, the court concluded that the IFPA was "clearly broad enough"[69] to support Allstate's contention that the

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[63] 693 A.2d 500 (N.J. Super. Ct. App. Div. 1997).

[64] *Id.* at 503 (emphasis added).

[65] *Id.* at 501 (citing N.J. ADMIN. CODE § 13:35-2.5(b)).

[66] *Id.* at 504.

[67] 746 A.2d 546 (N.J. Super. Ct. Law Div. 1999).

[68] *Id.* at 556.

[69] The [IFPA] was clearly intended by the Legislature to apply to more than just the most egregious acts of insurance fraud. For example, contrary to the defendants' interpretation of the [IFPA] as prohibiting only 'false written or oral representations,' Section 4(a) of the [IFPA] broadly applies to any "statement," which is expressly defined to include a bill or medical record that "contains any false or misleading information concerning any fact or thing material to the claim." [N.J. Stat. Ann. §] 17:33A-4(a)(1) and (2). It is also a violation of the [IFPA]

defendants had violated the IFPA, because each claim for reimbursement submitted by the defendants was a fraudulent representation that the facility in question complied with the regulations governing the ownership of diagnostic testing facilities.[70] And, thus, for the first time, the court sanctioned the notion that a failure to adhere to a licensing regulation could, on its face, constitute a violation of the IFPA.

Similarly, in *Material Damage Adjustment Corp. v. Open MRI of Fairfield,* the court concluded that "the [defendant] was not legally entitled to receive compensation under [the AICRA] for radiological services provided to its [patients] during a two[-]year period when defendant was not licensed by the State Department of Health and Senior Services."[71] Once again the IFPA was read extremely broadly, and the failure to comply with regulations governing the licensure of diagnostic imaging facilities through the Department of Health was determined to be a violation of the IFPA. The turning point in the case was the court's contention that by signing the relevant claim form, the facility's representative certified to having the right or authority to perform the services being submitted for payment.[72] Importantly, *Open MRI* went further than even *Schick,* in that the court also found that the statutory prerequisite for treble damages was met by the unlicensed facility's repeated submission of "fraudulent" claims.[73]

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if a person '[c]onceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to (a) any insurance benefit or payment . . . .' [N.J. STAT. ANN. §] 17:33A-4a(3) (2007).

Id.

[70] *Id.*

[71] 799 A.2d 731, 733 (N.J. Super. Ct. Law Div. 2002).

[72] *Id.* at 733.

The HICF requires the signature of the physician or 'supplier' of the services, including listing the "degrees or credentials" of the signer. *Webster's New Universal Unabridged Dictionary* defines credentials as 'evidence of authority, status, rights, entitlement to privileges, or the like, usually in written form.' Therefore, by signing the HICF, Open MRI's representative was attesting to its licensing status, to its right or authority to perform these diagnostic services and received payment under the PIP provisions of the insured's automobile policy.

Id. at 740.

[73] [T]here is no question that plaintiff is entitled to treble damages. At the risk of belaboring the obvious, Open MRI's fraudulent claims and receipt of insurance payments all involved the same victim, plaintiff NCIC. During the relevant time period, September 1997 to June 1999, Open MRI submitted hundreds of claims and received thousands of dollars from the plaintiff as payment for these claims.

The legal underpinnings of the *OEI*, *Schick*, and *Open MRI* holdings were again affirmed in *Allstate Ins. Co. v. Greenberg*.[74] In *Greenberg*, the court granted Allstate's motion for summary judgment and held that Dr. Greenberg, a licensed chiropractor, and his corporations "knowingly violated" the IFPA because: (1) Dr. Greenberg unlawfully owned a diagnostic testing facility, in violation of the same licensing regulation implicated in *Schick*;[75] (2) Dr. Greenberg unlawfully employed a plenary licensed physician in violation of another regulation promulgated by the Board of Medical Examiners;[76] and (3) each and every referral from one of Dr. Greenberg's chiropractic offices to Dr. Greenberg's diagnostic testing facility constituted an unlawful referral fee in violation of his own licensing regulations.[77] In so doing, the court also held that Dr. Greenberg had engaged in a pattern of fraudulent submissions and thus awarded treble damages to Allstate.[78] While the *Greenberg* case did not introduce any new theory of recoupment under the IFPA, it

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Id. at 742.

[74] 871 A.2d 171 (N.J. Super. Ct. Law Div. 2004).

[75] Medical screening or medical diagnostic testing (other than clinical laboratory testing), conducted primarily for persons not receiving medical treatment from the testing entity, is nevertheless deemed to be a medical service. Such a practice shall be owned and under the responsibility of one or more physicians each of whom holds a plenary license from the State Board of Medical Examiners. All such testing, irrespective of the stationary or mobile nature of the facility, shall be performed under the authority of a designated responsible physician who shall establish a protocol and a quality assurance program for the specific type of screening or study.

Id. at 175 (quoting N.J. ADMIN. CODE § 13:35-2.5(b).

[76] [A] practitioner with a plenary license shall not be employed by a practitioner with a limited scope of license, nor shall a practitioner with a limited license be employed by a practitioner with a more limited form of limited license. By way of example, a physician with a plenary license may be employed by another plenary licensed physician, but an M.D. or D.O. may not be employed by a podiatrist (D.P.M.) or chiropractor (D.C.).

Id. at 177 (quoting N.J. ADMIN. CODE § 13:35-6.16(f)(3)).

[77] It shall be professional misconduct for a licensee to pay, offer to pay, or to receive from any person any fee or other form of compensation for the referral of a patient. The within prohibition shall not prohibit the division of fees among licensees engaged in a bona fide employment, partnership or corporate relationship for the delivery of professional services.

Id. at 179 (quoting N.J. ADMIN. CODE § 13:44E-2.7). The court determined that because Dr. Greenberg "held a financial interest in Middlesex Diagnostic, every referral from a Greenberg chiropractic facility to Middlesex Diagnostic generated payment to Greenberg, which constituted an impermissible referral fee." *Id.*

[78] *Id.* at 181-82.

lent further credence to the essential holdings of *OEI, Schick,* and *Open MRI,* albeit on a particularly egregious set of underlying facts.

And finally, in *Varano, Damian & Finkel, L.L.C. v. Allstate Ins. Co.,*[79] the Appellate Division overturned the Law Division's prior grant of summary judgment to plaintiff, enforcing a settlement whereby Allstate had agreed to pay for claims submitted under an automobile policy.[80] The court concluded that Allstate was not estopped from opting out of the prior settlement, and thereafter alleging that the provider medical corporation was in fact owned and operated by a chiropractor and not a plenary licensed physician, as is required by the same licensing regulation implicated in *Greenberg.*[81] Based on the specific facts presented, the Appellate Division refused to assume original jurisdiction in order to grant summary judgment to Allstate, and remanded for further proceedings to determine if, at the time of the original settlement, Allstate had knowledge of the plaintiff's illegal practice structure.[82] Nevertheless, *Varano* was significant because it appears to ratify the broad expansions of *OEI* that *Schick, Open MRI* and *Greenberg* represent. The question remains, however, as to whether or not future courts will continue to build upon *OEI* and its progeny.

Regardless of any further expansion of the breadth and scope of the IFPA, a provider found to have failed to satisfy the recordkeeping requirements of his or her licensing board[83] should not be subjected to liability under the Act because an essential element of the *OEI* decision precludes such a result. *OEI* addressed licensure violations that *bear directly upon the nature of services provided.* Because patient records are not completed until after the corresponding service has been rendered, it is entirely logical to conclude that recordkeeping does not bear *directly* upon the nature or performance of those services. Moreover, *OEI, Schick, Open MRI,* and *Greenberg* are all rooted not only in the policy interest of combating insurance fraud, but also in the public safety interest of ensuring that medical services are only provided by healthcare professionals with the requisite qualifications to perform them. When a provider simply fails to adequately perform a purely administrative function, these public safety concerns are not implicated. Thus, there is a clear legal and factual distinction between a failure to adequately document a

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[79] 840 A.2d at 262.
[80] *Id.* at 266.
[81] *Id.* at 264.
[82] *Id.* at 266.
[83] *See supra* note 10.

patient's care and a failure to *render* that care appropriately.

V. Conclusion

Public policy—and common sense—requires that a clear delineation be made between administrative shortcomings and abject fraud. First, in crafting both the Independent Health Care Appeals Program and the new binding arbitration system, the New Jersey legislature made an incontrovertible policy choice to impose more finality on the claims payment process and to limit the exposure of a provider whose innocent mistakes may lead to unjust enrichment. Only by limiting less culpable overpayment liability to eighteen months worth of claims can this goal be effectuated. Second, because of the disproportionate resources available to providers and carriers, it is critical that we avoid, where possible, subjecting honest providers to a circumstance where they are forced to settle on drastically unfavorable terms because of an inability to endure a lengthy and costly litigation. And finally, to adopt a contrary rule would inevitably lead to absurd results. If a failure to adequately document was in and of itself a violation of the IFPA, even the most innocuous shortcomings, such as failing to sign each and every daily treatment note, would represent a fraudulent act. Five such absent minded lapses would then arguably demonstrate a pattern of fraud, thus subjecting a provider to treble damages. This kind of perverse result cannot possibly be sanctioned. While organized, legible and detailed treatment notes are important, it is much more important that we do not unnecessarily burden providers with administrative hurdles that will negatively impact their ability to do that which they do best: to put all of their efforts into helping their patients get well.

The detection and prevention of insurance fraud *must* be a two-way street. With the considerable latitude that has been properly afforded to insurance carriers in rooting out the reprehensible conduct of a select few, comes an equally great responsibility to demonstrate restraint as it relates to the vast majority of providers—those noble health professionals who strive on a daily basis to meet the needs of their patients. Unfortunately, when left to their own devices, many insurance carriers are incapable of demonstrating any semblance of temperance and the enforcement pendulum appears to have swung too far in the insurance industry's favor. The HCAPPA was a laudable start towards remedying the existing breach, but unfortunately, the loopholes in that statute have rendered it somewhat toothless. The solution, however, is remarkably simple:

providers should be placed on the same footing as carriers. Much in the same way that the IFPA confers attorney's fees and the costs of investigation to an insurance carrier that successfully asserts a claim for statutory fraud, new legislation is needed to grant a similar remedy to inappropriately aggrieved providers. If an insurance carrier asserts a fraud claim, and is thus successful in denying a provider access to the rights and remedies created under the HCAPPA, it should be held to pay for a provider's attorney's fees and reasonable costs of successfully defending that fraud suit. In addition to this "quick" fix, the HCAPPA must ultimately be amended to include clear and unambiguous requirements that must be met before an insurance carrier can unilaterally eviscerate a provider's statutory rights.