Superior Court of New Jersey

Appellate Division

Docket No. A-002430-07T3

JOSEPH GARCIA, M.D., *et al.*,	:	CIVIL ACTION
Plaintiffs-Appellees,	:	SUPERIOR COURT OF NEW JERSEY
vs.	:	APPELLATE DIVISION
HEALTH NET OF NEW JERSEY, INC.,	:	BERGEN COUNTY
Defendant-Appellant,	:	
vs.	:	
WAYNE SURGICAL CENTER, LLC, *et al.*,	:	
Third-Party Defendants-Appellants.	:	

AMICUS BRIEF OF MEDICAL SOCIETY OF NEW JERSEY AND THE AMERICAN MEDICAL ASSOCIATION

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STATEMENT OF THE MATTER INVOLVED

Amici the Medical Society of New Jersey ("Medical Society") and the American Medical Association ("AMA") urge this Court to affirm the trial court's decision granting summary judgment in favor of Wayne Surgical Center, LLC ("Wayne") and its surgeon owners, and to clarify certain issues addressed by the trial court which may substantially affect the manner in which health services in New Jersey are provided in the future. The legal arguments urged by Appellant Health Net of New Jersey, Inc. ("Health Net") and certain amici would expose thousands of New Jersey physicians to unforeseen liability for insurance fraud under the Insurance Fraud Prevention Act ("IFPA"), N.J. Stat. Ann. §§ 17:33A-1 et seq.

The trial court correctly decided that Wayne and its surgeon owners reasonably believed that they were lawfully referring their patients to ambulatory surgery centers ("ASCs") because (1) physician-owned ASCs are a widespread form of providing surgical services in this State and have been for many years,[1] (2) Wayne and the other physician-owned ASCs in this State are operating openly and are taxed, regulated and audited by the State, and (3) their existence is well known to New

[1] As of 2006, there were 95 state licensed ASCs in New Jersey, as well as numerous smaller unlicensed facilities. Advalere Health LLC, 2006 New Jersey Health Care Almanac at 31. Available at: http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf (last visited September 18, 2008).

Jersey enforcement authorities, yet no steps have ever been taken to declare the practice unlawful. (Da 33.) The trial court further correctly held that Wayne's policy of not pursuing collection of co-insurance from patients is lawful. (Da 36.) The court thus granted summary judgment in favor of Wayne and its surgeon owners because, on the undisputed facts, there was no evidence of a "knowing" failure to disclose "material" information on Wayne's reimbursement claim submissions.

In this appeal, Health Net seeks to eliminate the longstanding requirement that a practitioner may only be held liable for fraud under the IFPA if he or she "knowingly" submits a "materially" false or misleading statement. Health Net asks this Court to rewrite the IFPA to expose every physician in New Jersey to prosecution and liability for insurance fraud -- for purportedly providing medically necessary services -- if he or she has unknowingly violated any of a myriad of extensive state or federal regulations. Indeed, under Health Net's interpretation, a practitioner would be required to submit an addendum to all reimbursement claim submissions listing all potential or conceivable violations of state and federal law. Health Net's urged interpretation is contrary to the Legislature's clear intent when it enacted the IFPA, is not supported by the case law in this State, and would substantially harm the medical profession in New Jersey.

Based on the correct interpretation of the IFPA's scienter requirement, Health Net has failed to prove fraud because there is no evidence in the record that Wayne "knowingly" submitted "materially" false or misleading claims. There is no evidence in the record that Wayne knew, or should have known, that: (1) its ownership structure violated the Codey Act (let alone that its ownership structure should have been disclosed on a claim submission that didn't request such information), or that such an omission would have been material to Health Net's reimbursement decision; or (2) its collection practices were unlawful (let alone that this information should have been disclosed on a claim submission), because Wayne's collection practices were entirely lawful. Accordingly, amici respectfully submit that holding Wayne liable for "knowing" fraud (or indeed, of any violation of law) under these factual circumstances would be an incorrect interpretation of the IFPA, and would create a substantial disruption to the delivery of health care services in New Jersey.

Although plainly not necessary to decide this case, the trial court also considered the legality of Wayne's surgeon ownership structure under the Codey Act. Consideration of the trial court's dicta is unnecessary because, as the record shows, both the Legislature, led by Senator Codey himself, and the New Jersey Board of Medical Examiners ("BME"), the regulatory body

responsible for implementing and interpreting the Codey Act, are currently considering legislation and regulations which would clarify that physician-owned ASCs such as Wayne do not violate the Codey Act. Thus, amici urge that this Court not reach the substance of the trial court's Codey Act analysis.

In the event this Court chooses to reach this issue, the Medical Society and the AMA respectfully request that the Court reverse this aspect of the trial court's finding and rule that under the facts of this case, Wayne and its surgeon owners did not violate the Codey Act. The Legislature did not intend for the Codey Act to prohibit legitimate surgeon referrals to surgical facilities, such as Wayne, because the improper incentive for self-referrals is insignificant in this context. If followed by other courts, the trial court's dicta would deprive physicians and patients of the substantial benefits that physician-owned ASCs provide to patients, physicians, and the medical community.

FACTS

The relevant facts of this matter are set forth in detail in the Joint Brief of Respondents and are undisputed, so will not be repeated at length here. We emphasize a few salient facts, which we believe will bear on the Court's decision.

It is undisputed that Wayne is an ASC licensed by the State of New Jersey, and that Wayne's surgeon owners use Wayne to

perform surgeries on their patients. (Da 11-12.) It is also undisputed that Wayne's surgeon owners were participating providers in Health Net's insurance network, and that they submitted claims for services to Health Net, including for surgeries performed at Wayne. Id. However, these claims are not the subject of this dispute and Health Net has never raised any allegations of fraud (such as billing for services not rendered) with respect to claims for surgical services performed at Wayne.

In contrast with its surgeon owners, Wayne itself is not a member of Health Net's insurance network, so Wayne does not have a contract with Health Net setting forth the terms under which Health Net must make payments for Wayne's facility services. Id. Instead, Wayne submits its insurance claims to Health Net as an assignee of its patients to receive out-of-network reimbursement for facility fees, and the patients remain responsible for paying any outstanding fees not collected from insurance companies. Id. Wayne's claims for facility fees are the subject of this dispute.

This case commenced when certain of Wayne's surgeon owners sued Health Net, charging that it improperly declined to renew their in-network contracts relating to their private surgical practices. Health Net counterclaimed that Wayne and its surgeon owners violated the IFPA by submitting claims for Wayne's

surgical facility fees that did not disclose Wayne's surgeon ownership structure and did not disclose Wayne's practice of writing off patient co-insurance obligations after receiving payment from insurance companies. Health Net argued that these omissions were fraudulent, even if Wayne did not intentionally, recklessly or even negligently omit the purported violations of New Jersey law.

The trial court found undisputed evidence that Wayne and its surgeon owners believed that both the referrals and the non-collection of co-insurance were entirely lawful. As to Wayne's ownership structure, the trial court found no proof, nor even a claim, that Wayne's surgeon owner referrals to Wayne were based on "anything but sound, medical decision-making." (Da 27-28.) Further, the trial court found that the practice of physician-owned ASCs is "widespread," and "enforcing authorities of the State of New Jersey are well aware of [the practice] but have taken no steps to declare the practice unlawful." (Da 21.) Based on this undisputed evidence, as well as the lack of clarity as to the Codey Act's treatment of ASCs, the trial court held that "there was not even negligence on the part of the doctors, let alone conscious wrongdoing, or reckless indifference to wrongdoing." (Da 33.)

With respect to Wayne's decision not to collect patient co-insurance, the record reflects that Wayne's Chief Operating

Officer made a decision in 1999, after consultation with attorneys and members of the BME, to accept payment from insurance companies as payment in full in most (but not all) cases. (Pa 55.) There is no evidence that Wayne made this decision in order to encourage patients to use its facilities. To the contrary, it is undisputed that Wayne's patients were required to sign a document acknowledging that they were fully responsible for 100 percent of Wayne's facility fees, and that Wayne did not discuss co-insurance with patients, let alone tell them that it would waive its right to collect co-insurance. (Pa 53.)

It is also undisputed that Health Net did not specifically request information from Wayne about its collection practices, and that Wayne never represented to Health Net that it did (or did not) collect co-insurance from patients. In fact, Wayne collected co-insurance in certain limited circumstances, such as when Wayne did not receive any payment from the patient or insurance company. (Pa 54-55.) Given these undisputed factual circumstances, the trial court held that Wayne's collection practices were entirely lawful. (Da 36.)

LEGAL ARGUMENT

I. The Trial Court Correctly Held that Health Net Must Prove that Wayne "Knowingly" Submitted Claims that were "Materially False or Misleading."

Pursuant to N.J. Stat. Ann. § 17:33A-4, Health Net bears the burden of proving that Wayne and its surgeon owners violated the IFPA, which permits insurance companies to recover damages against any person who:

> (1) Presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy . . . knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or
>
> (2) Prepares or makes any written or oral statement that is intended to be presented to any insurance company . . . or in support of or opposition to any claim for payment or other benefit pursuant to an insurance policy . . . knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or
>
> (3) Conceals 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 or (b) the amount of any benefit or payment to which the person is entitled;

Each element of an IFPA violation -- knowledge, materiality, and a false or misleading statement -- must be proved by a preponderance of the evidence. Liberty Mut. Ins. Co. v. Land, 186 N.J. 163, 175 (N.J. 2006). This record simply contains no evidence that Wayne submitted claims to Health Net (1) "knowing"

(2) that the claims were "materially false or misleading." Health Net thus cannot satisfy the elements of an IFPA claim.

A. Health Net must prove scienter, i.e., deliberate or conscious omission of material information from claims.

1. The IFPA's "knowing" language establishes an unambiguous scienter requirement.

A medical service provider such as Wayne can be held liable under the IFPA only if it submits an insurance claim to an insurer "knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim." N.J. Stat. Ann. § 17:33A-4 (emphasis added). Given this unambiguous language, the trial court correctly held that Health Net must prove scienter in order to satisfy the IFPA's "knowing" element.[2] See Bryan v. United States, 524 U.S. 184, 188 (1998) (recognizing that the federal legislature added a scienter element to the Firearm Owner's Protection Act by adding the term "knowingly" to three categories of offense under the statute).[3]

[2] As the State acknowledges, scienter means "knowingly." State's Brief at 3 (citing Black's Law Dictionary 1347 (7th ed. 1999) ("[Latin 'knowingly']. A degree of knowledge that makes a person legally responsible for the consequences of his or her act or omission; the fact of an act having been done knowingly, esp. as grounds for civil damages or criminal punishment.")).

[3] Health Net's citation to Bryan merely suggests that a defendant cannot assert his lack of awareness of a statutory violation as a defense to that violation, where "[t]he evidence was unquestionably adequate to prove that petitioner . . . knew that his conduct was unlawful." Bryan, 524 U.S. at 188. In contrast, Wayne and its surgeon-owners reasonably believed their conduct was lawful and have not asserted ignorance of the IFPA as a defense to this action.

The IFPA does not define the terms "knowing" or "knowingly," so the Court must ascribe to these statutory terms "their ordinary meaning and significance, and read them in context with related provisions so as to give sense to the legislation as a whole." DiProspero v. Penn, 183 N.J. 477, 492-93 (N.J. 2005). Under New Jersey law,

> [a] person acts knowingly with respect to the nature of his conduct or the attendant circumstances if he is aware that his conduct is of that nature, or that such circumstances exist, or he is aware of a high probability of their existence. A person acts knowingly with respect to a result of his conduct if he is aware that it is practically certain that his conduct will cause such a result.

N.J. Stat. Ann. § 2C:2-2(b)(3). In the context of alleged fraudulent statements, "knowing" is understood to mean deliberate, conscious, and/or intentional.[4] See Cumberland Mut. Fire Ins. Co. v. Murphy, 183 N.J. 344, 354 (N.J. 2005) ("'knowing' can mean both 'conscious' and 'intentional'"). Health Net is thus required to prove that Wayne deliberately or consciously omitted information from its claims and that Wayne intended that the claims be materially false or misleading based on this omission.

[4] Black's Law Dictionary defines "knowing" as "deliberate; conscious," i.e., "a knowing attempt to commit fraud"). Black's Law Dictionary 876 (7th ed. 1999); see also Webster's II New College Dictionary 610 (2001) ("deliberate," i.e. "knowing complicity"); Dictionary.com, http://dictionary.reference.com/browse/knowing ("conscious; intentional; deliberate").

Nevertheless, Health Net asks the Court to ignore the plain meaning of "knowing," and instead hold Wayne and its surgeon owners strictly liable for failing to list every potential violation of federal and state regulations on insurance claim forms (even though the forms do not call for such information). To reach this result, Health Net introduces an unprecedented -- and unreasonable -- imputation theory. First, Health Net asks the Court to charge Wayne and its surgeon owners with knowledge of the correct interpretation of all statutes and regulations relating to Wayne's medical practice. Second, it asks the Court to impute that knowledge to Wayne in order to satisfy its burden of proving that Wayne omitted potential violations from insurance claims "knowing" that the omission made the claims materially false or misleading.

Simply put, Health Net's argument requires egregious and unwarranted bootstrapping. Even though the trial court held, and Health Net does not dispute, that Wayne reasonably believed that it did not omit material facts from its claim submissions, Health Net essentially asks the Court to hold Wayne strictly liable if it turns out that Wayne's reasonable, good faith interpretations of New Jersey law are incorrect. Not only would this interpretation of the IFPA lead to absurd results, but it is contrary to the plain meaning of the term "knowing," as well

as ample authority providing that the IFPA's "knowing" element requires proof of scienter.

2. Health Net's argument that cases decided under the Consumer Fraud Act support an interpretation that scienter is not required under the IFPA is without merit.

Although Health Net and certain amici cite the Consumer Fraud Act, N.J. Stat. Ann. 56:8-1 to-106 ("CFA"), as authority that the IFPA does not require scienter, a close review of the statute and case law interpreting the CFA show that plaintiffs must prove scienter to show a "knowing" omission under the CFA. Indeed, the cases relied upon by Health Net support this position.[5]

The CFA provides:

> The act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment,

[5] Violations of the CFA can be separated into two statutory prongs, (1) "[a]n affirmative misrepresentation, even if unaccompanied by knowledge of its falsity or an intention to deceive," and (2) "[a]n omission or failure to disclose a material fact, if accompanied by knowledge and intent," as well as a third prong for (3) "violations of specific regulations promulgated under the [CFA]." Monogram Credit Card Bank of Georgia v. Tennesen, 390 N.J. Super. 123, 133 (A.D. 2007).

Health Net and amici supporting its interpretation of the CFA cite only cases arising under the first and third prongs of the CFA to show that the IFPA does not require scienter. See Appellant's Reply Brief at 7; State's Brief at 10 (citing Gennari v. Weichert, 148 N.J. 582, 608 (1997); Herner v. Housemaster of America, Inc., 349 N.J. Super. 89 (App. Div. 2002); Ramapo Brae Condo. Ass'n, Inc. v. Bergen County Hous. Auth., 328 N.J. Super. 561, 575 (App. Div. 2000)). Even these cases are clear that the "knowing" element of the second prong requires proof of scienter. See Gennari, 148 N.J. at 605 ("One who makes an affirmative misrepresentation is liable even in the absence of knowledge . . . For liability to attach to an omission or failure to disclose, however, the plaintiff must show that the defendant acted with knowledge.").

> suppression or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise or real estate, or with the subsequent performance of such person as aforesaid, whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice.

N.J. Stat. Ann. § 56:8-2 (emphasis added). Under the express language of the CFA, affirmative misrepresentations and violations of specific regulations are actionable whether or not they are known, while omissions of material fact are actionable only if they are known. See Chattin v. Cape May Greene, Inc., 243 N.J. Super. 590, 598 (App. Div. 1990) ("the court must clearly explain to the jury the difference between the kinds of consumer fraud consisting of affirmative acts, which may be committed without a showing of intent, and acts of omission, which must be committed 'knowingly' in order for liability to be imposed under the Consumer Fraud Act").

In contrast to the CFA, the New Jersey Legislature specifically included a "knowing" or "knowingly" element for all three prongs of the IFPA (i.e., prongs one and two both require, "knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim," and prong three requires, "knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement"). Therefore, Health Net's

reliance on cases interpreting the first and third prongs of the CFA is misplaced because neither prong requires the "knowing" element provided by the IFPA.

Significantly, cases that have interpreted the second prong of the CFA have reached the same conclusion as the trial court did in this case, that a showing of scienter is required. See Ji v. Palmer, 333 N.J. Super. 451 (App. Div. 2000) (holding that a real estate broker was not liable to his client under the CFA for failing to tell the client that the subject property was zoned only for single-family residential use, where the broker did not know about the zoning restriction). Accordingly, the CFA provides strong support that scienter is required under the IFPA.

3. The pre-1986 Federal False Claims Act's "knowing" element required proof of intent to cheat the government.

A close federal analog to the "knowing" language of the IFPA is the pre-1986 Federal False Claims Act ("FCA"), 31 U.S.C.

§§ 3729, et seq.[6] Prior to 1986, the FCA contained a conventional knowledge requirement under which an FCA defendant could escape liability by demonstrating that the defendant did not intend to deceive the government. See, e.g., United States v. Thomas, 709 F.2d 968, 971-72 (5th Cir. 1983); United States v. Mead, 426 F.2d 118, 121 (9th Cir. 1970). However, in 1986, Congress decided to liberalize the FCA's knowledge requirement to expand the conduct covered by the FCA to false statements made in deliberate disregard or reckless indifference to the falsity of the statement. See S. Rep. No. 99-345, at 6-7, 1986 U.S.C.C.A.N. 5271-72 (recognizing that under the pre-amendment standard, "the government is unable to hold responsible those corporate officers who insulate themselves from knowledge of false claims submitted by lower level subordinates. The 'ostrich-like' conduct which can occur in large corporations poses insurmountable difficulties for civil false claims recoveries").

[6] In relevant part, the FCA creates liability for any person who:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government . . . [or]
> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government . . .

31 U.S.C. § 3729(a).

The amendment expanded the plain meaning of "knowing" or "knowingly" by statutory definition, to encompass a person who:

(1) has actual knowledge of the information; or
(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.

31 U.S.C. § 3729(b). To ensure that the amendment had its intended effect, Congress expressly provided that "[n]o proof of specific intent to defraud is required." Id. Still, a showing of a false statement alone or even negligence is insufficient to satisfy the FCA's amended scienter standard.

Thus, although the trial court did not determine the precise contours of the IFPA's scienter requirement, it correctly looked to pre-1986 FCA cases for guidance. In enacting the IFPA in 1983, the State Legislature made a conscious choice to adopt language that mirrored the pre-1986 FCA and thus the FCA's pre-1986 scienter standard, but it chose not to modify the meaning of the term "knowing" by amendment as did Congress in 1986.[7] To the date of this filing, the State

[7] It is apparent that the New Jersey legislature considers "knowing" to be a higher level of scienter than recklessness. For example, the legislature adopted the Health Care Fraud Act ("HCFA") in 1998, which established varying degrees of crimes for health care claims fraud, defined in relevant part, as "making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document . . . submitted for payment or reimbursement for health care services." N.J. Stat. Ann. § 2C:21-4.2. Significantly, under this statute, a practitioner is guilty of a second degree offense if he or she "knowingly" commits health care claims fraud in the course of providing professional

Legislature has never modified the IFPA's "knowing" requirement by amendment, even though it amended the IFPA in 1991, 1995, and 1997.[8]

Accordingly, given the statutory meaning of the term "knowing" in the IFPA and the evident legislative intent not to modify its meaning, there is no basis for the Court to alter the statute's requirement that insurance companies must prove scienter, which in this context means a deliberate or conscious omission from an insurance claim with the intent that the claim be materially false or misleading based on this omission.

B. Health Net must prove that claim omissions were material to its reimbursement decisions.

A statement or omission is material if "a reasonable person would attach importance to its existence in determining a choice of action." Ji v. Palmer, 333 N.J. Super. 451, 462 (App. Div. 2000) (citing Restatement (Second) of Torts § 538(2) (1977)). Thus, in the context of this IFPA action, Health Net must prove

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services, but guilty of the lesser third degree offense if he or she "recklessly" commits the fraud. N.J. Stat. Ann. § 2C:21-4.3.

[8] In adopting a False Claims Act in 2008 ("NJFCA"), the New Jersey Legislature defined knowledge identically to the FCA. "Knowing" or "knowingly" means, with respect to information, that a person:

> (1) has actual knowledge of the information; or
> (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.

N.J. Stat. Ann. §§ 2A:32C-2. The NJFCA clarifies that "[n]o proof of specific intent to defraud is required," and "[i]nnocent mistake shall be a defense to an action under this act." Id.

that omissions from Wayne's claim submissions would have been important to a reasonable insurer. Longobardi v. Chubb Ins. Co., 121 N.J. 530, 540-41 (N.J. 1990).

II. The Trial Court Correctly Held that Wayne did not "Knowingly" Submit Materially False or Misleading Claims by Omitting Information about Wayne's Ownership Structure.

A. There is no evidence in the record that Wayne "knowingly" omitted information about its ownership structure from its claim submissions.

The record provides extensive evidence showing that Wayne and its surgeon owners reasonably believed that Wayne's ownership structure was entirely lawful, including: (1) the practice of physician-owned ASCs is "widespread, and the enforcing authorities are indeed well aware of it and have taken no steps to halt the practice or prosecute the practitioners," (Da 21.); (2) the only opinion from the BME, the regulatory body charged with interpreting the law, said that "it does not deem a surgeon's referral of his or her own patient to an ACS in which he has an interest an impermissible self-referral," (Pa 173.); and (3) "there is nothing in the record to even suggest that any patient was ever referred to the Center for a procedure that was not needed, nor that the decision to recommend the surgery, or to perform the surgery, was in any way colored by the fact that

the doctor had an ownership interest in the facility at which the procedure ultimately took place." (Da 27-28.)[9]

Health Net cites two cases, Allstate Ins. Co. v. Greenberg, 376 N.J. Super. 623 (Law Div. 2004) and Material Damage Adjustment Corp. v. Open MRI of Fairview, 352 N.J. Super. 216 (Law Div. 2002), to support its argument that Wayne and its surgeon owners are strictly liable for purported violations of statutes or regulations under the IFPA; however, these cases are inapposite.

First, both cases involved claims submitted by unlicensed physicians for reimbursement of Personal Injury Protection ("PIP") benefits pursuant to the PIP reimbursement scheme, which requires a license, inter alia, as a requisite for reimbursement. Greenberg, 376 N.J. Super. at 636 (holding that fees for the services rendered based upon knowing self-referrals "are not eligible for PIP reimbursement as a matter of law"); Material Damage, 352 N.J. Super. at 229 (holding that Open MRI

[9] Significantly, Wayne's COO Dennis Simmons, who bore sole responsibility for the day-to-day management and decision-making at Wayne, has performed substantial due diligence as to the legality of physician-owned ASCs during his career. (Pa 18, Simmons Cert. ¶¶ 1-3.) Prior to Wayne's existence, Mr. Simmons worked at Complete Management, Inc. on a potential acquisition of a controlling interest in an ASC operating in New Jersey. (Id. at ¶ 2.) Through his work on that transaction, Simmons and Complete Management obtained advice from attorneys of the law firm Epstein, Becker & Green, as well as the New Jersey Department of Health and Senior Services and the BME, that it is legal for a surgeon to perform surgery on patients from his private practice at an ASC in which he holds an ownership interest. (Id. at ¶¶ 3-4.) Once Mr. Simmons joined Wayne, this experience informed his work as COO, and it provides further evidence that persons looking at the state of the facts and law could have reasonably concluded that Wayne's structure was legal.

was not eligible to receive PIP reimbursement for magnetic resonance imaging services). Thus, the fact that this case does not involve claims for reimbursement pursuant to PIP by itself distinguishes Greenberg and Material Damage, because Wayne and its surgeon owners have not violated a regulatory scheme which provides their sole basis for reimbursement.

Second, the facts of this case are distinct because, as the trial court found, Wayne and its surgeon owners reasonably believed that they did not violate the IFPA. (Da 33.) This finding stands in stark contrast to Material Damage, where the Court determined that Open MRI's unlicensed operations "represent a flagrant violation of [PIP's] statutory and regulatory requirements," Open MRI "was a rogue operation, functioning completely outside the law," "Open MRI's decision to operate this MRI facility without the required license was clearly the product of arrogance," "they knew the legal process involved," and Open MRI's "clear contempt for the rule of law cannot find judicial countenance." Id. at 227. Similarly, in Greenberg, the trial court found that the defendant utilized an "intricate scheme to create five chiropractic clinics which referred all the patients of Middlesex Diagnostic and also created a separate billing company that charged 30%," which scheme "was obviously designed to maximize profits-particularly

with reference to Middlesex Diagnostic." Greenberg, 376 N.J. Super. at 631.

To overcome the trial court's finding that Wayne "reasonably believed" in the lawfulness of its ownership structure, Health Net cites language from Material Damage suggesting that "even a good faith belief that one is performing [medical] services in a reasonable or otherwise sound manner is not a defense" to a violation of PIP. Material Damage, 352 N.J. Super. at 229. However, the Court in Material Damage addressed the common situation where a defendant, usually in the criminal context, claims that he did not know that his conduct was illegal. The Court merely rejected the defense that ignorance-of-the-law is an excuse for violating the law, and did not extend this principle to the situation where a "knowing" violation is an element of the offense. Therefore, while it may be argued that Wayne could not offer its belief that its ownership structure was lawful as a defense to prosecution under the Codey Act, this does not mean that a plaintiff such as Health Net can avoid its obligation to prove a "knowing" violation under the IFPA by relying on the ignorance-of-the-law is an excuse doctrine. See supra Part I.

Accordingly, Health Net cites no case law supporting IFPA liability based on factual findings similar to the findings in this case. Specifically, no court has found a defendant liable

under the IFPA for unknowingly violating a statute unrelated to its request for reimbursement. If the Court were to hold Wayne and its surgeon owners liable under these factual circumstances, doctors would be exposed to limitless IFPA liability and a flood of insurance company lawsuits asserting that doctors had an incorrect interpretation of law, however reasonably held. This Court should not countenance such a fundamentally unfair result.

B. There is no evidence in the record that Wayne's ownership structure was material to Health Net's reimbursement decisions.

There is no evidence in the record that Health Net considered or should have considered Wayne's ownership structure to be important to its reimbursement decisions. Rather, this information is irrelevant to Health Net.

First, the Codey Act is intended to ensure that patient treatment decisions are based on sound medical decision-making. See Greenberg, 376 N.J. Super. at 635 ("The Legislature's concern clearly was centered around the belief that practitioners with financial interests in entities are more likely to base their referrals on financial motives instead of sound medical decision-making."). Here, the record reflects no proof, or even a claim, that Wayne's surgeon owners made any referral to Wayne based on anything but sound medical decision-making. (Da 27-28.) ("There is no proof or claim that any patient referred to the Center should – from a purely medical

and patient-care prospective – have been referred instead to a hospital, or some other arrangement.")

Second, the record shows that the State actively regulates physician-owned ASCs, yet State regulators were not concerned with the physician-owned business model and obviously did not consider the structure to be a material concern for patients or insurance companies. (Da 33.) The policy rationale for prohibiting self-referrals does not apply to ASCs such as Wayne because there is little danger that Wayne's surgeons would subordinate their surgical judgment based on the financial incentive of a shared facility fee. Simply put, Wayne's facility services are merely an extension of the physician's primary surgical responsibility to their patients. (Pa 174).

Third, the record does not reflect that Health Net considered Wayne's physician ownership structure to be material to its claim determination. To the contrary, the record shows that physician-owned ASCs are ubiquitous in New Jersey, and that Health Net was aware or should have been aware that many of the ASCs that submitted claims to Health Net, such as Wayne, were surgeon owned. (Da 33, 37.) Thus, Health Net's failure to request surgeon ownership information on its claim forms, to inquire with Wayne as to its ownership structure, or to look into Wayne's publicly available ownership records is compelling

evidence that Health Net did not treat this information as material.

Further, Health Net has not suggested that it has denied or plans to deny any claims made by physician-owned ASCs. Indeed, Health Net only brought this IFPA action as a counterclaim in the lawsuit brought by Wayne's surgeon owners. If Wayne's physician ownership structure were truly material to Health Net, it would have brought IFPA claims many years ago against the numerous physician-owned ASCs submitting insurance claims to Health Net in New Jersey.

III. The Trial Court Correctly Held that Wayne did not "Knowingly" Submit Materially False or Misleading Claims by Omitting Information about its Collection Practices.

A. Wayne's omission of information about its collection practices did not violate the IFPA because its collection practices were entirely lawful.

The trial court correctly held that Wayne and its surgeon owners did not violate the IFPA because Wayne's decision to write off patient co-insurance obligations was entirely lawful, particularly given undisputed evidence that: (1) Wayne never contractually waives a patient's legal responsibility for paying facility fees, and, in fact, requires patients to sign a form stating that the patient is fully responsible for 100 percent of Wayne's charges, (Pa 53; Simmons Dep. 57:4-10.); and (2) Wayne never promises its patients a waiver of facility fees or even discusses a potential waiver, let alone induces patients to use

its facilities through such a waiver, (Pa 54; Simmons Dep. 62:17-63:7.); (Da 33.) (finding "no authority to establish that the doctors or the Center acted unlawfully in routinely failing to enforce the obligation of Health Net subscribers to pay co-insurance").

Moreover, Health Net never specifically requested and Wayne never provided Health Net with information about its collection practices. Importantly, Wayne could not have accurately disclosed to Health Net the fact or the amount of a patient's write-off, if any, because Wayne would not know the amount of a patient's co-insurance obligation until after it received reimbursement from the insurance company. (Pa 451.) Thus, the trial court correctly recognized that "[t]he failure to disclose the amount of co-insurance on claim forms is . . . not a fraudulent act where, as here, the amount cannot be known at the time the form is submitted, and where there is no misrepresentation as to the amount of the co-insurance, nor that it has or will be collected." (Da 33.)

Nevertheless, Health Net argues that health care providers should be held per se liable for failing to disclose co-insurance write-offs. Obviously, Health Net's position would have a dramatic impact on New Jersey physicians, who would be left without any guidance as to the steps they must take with respect to unpaid bills. Thus, the judiciary would be in the

position of setting forth rules concerning the collection of co-insurance that would apply to every physician practicing in New Jersey, which is the responsibility of the State Legislature and administrative agencies.[10]

To support its position, Health Net relies on two cases involving waiver of co-insurance prior to claim submission, as opposed to post-claim collection practices, which are thus clearly inapposite. See Feiler v. New Jersey Dental Association, 467 A.2d 276 (App. Div. 1983) (New Jersey Dental Association brought a deceptive practice action against a dentist claiming that he made false statements to carriers overstating his patient charges because he was advertising that he would waive co-insurance); Aetna Health, Inc. v. Carabasi Chiropractic Center, Inc., 2006 WL 66460, at *3 (App. Div. 2006) (unpublished) (holding that Aetna's allegation that Carabasi "waived patients' co-insurance but failed to disclose that to Aetna on the claims forms," if proven, could give rise to a claim for fraud).

First, Feiler was not an action under the IFPA so none of its holdings are directly applicable. Second, Feiler involved

[10] Without such guidance, physicians would have no certainty as to how to insulate their collection practices from claims of insurance fraud. Would it be enough to send a bill to every patient? Would physicians need to make efforts to collect? If so, what specific efforts? Would physicians need to hire a collection agency or commence litigation? Clearly, this type of guidance would encroach on a physician's ability to make appropriate business decisions for his or her practice.

an unfair competition claim against a dentist, which is an entirely different context than an insurance company's fraud claim against a physician. See Feiler, 467 A.2d at 280. Third, Feiler involved a dentist who affirmatively used waiver as a marketing tool to gain a competitive advantage. Id. at 282 (finding that Feiler "promised the patient that he will not collect the patient's portion of the charges," and "Feiler publicly announces and encourages unions loyal to him to announce that he forgives copayments"). Importantly, the facts in this case show, rather than employing waiver as a marketing tool, that Wayne was merely making a case-by-case decision for business reasons not to pursue collection. (Pa 55.)

Aetna Health is similarly unhelpful, as the Court merely held that under the appropriate set of facts, where a physician affirmatively waived his patients' co-insurance obligations prior to performing the procedure, yet failed to disclose such waiver to the insurance company, such a set of facts could give rise to liability under the IFPA. Aetna Health, 2006 WL 66460, at *3. This holding is easily distinguishable from the facts of this case, where no actual waiver occurred and where a decision was made by Wayne, not the physicians, to forego collection of certain, but not all co-insurance.

Health Net's arguments fail to recognize the unique nature of the incentives created by the ASC model generally. Unlike

cases involving dentists or chiropractors, where doctors have an incentive to waive co-insurance to compete for patients on the basis of cost, patients referred to ASCs are pre-existing patients of the surgeon owners performing the surgeries. Patients choose their facility based on the advice of their surgeon, not the potential for a future write-off. In the instant case, the record provides no evidence that Wayne's surgeon owners use potential write-offs as a financial inducement to choose Wayne. Rather, Wayne's surgeon owners provide patients with a myriad of legitimate medical reasons to have the procedures performed at Wayne (e.g., superior service and convenience). (Pa 91, 94, 100, 116, Dr. Baratta Dep. 17:2-25, Dr. Ginsburg Dep. 21:14-22:12, Nicosia Dep. 18:2-19, Dr. Schlecker Dep. 17:20-18:10.)

Thus, Feiler and Aetna stand at most for the proposition that doctors cannot legally waive patient responsibility for paying co-insurance before they submit claims. No court has extended this limitation to co-insurance collection or write-off practices. Accord Trustmark Life Ins. Co. v. University of Chicago Hospitals, 207 F.3d 876, 884 (7th Cir. 2000) (holding that a medical service provider does not void its contract with the insurance company by its non-collection of co-insurance because the patient remained legally responsible to pay for outstanding medical coverage fees); Kennedy v. Connecticut

General Life Ins. Co., 924 F.2d 698, 702 (7th Cir. 1991) (holding that if a medical service provider "wishes to receive payment under a plan that requires co-payments, then [it] must collect those co-payments -- or at least leave the patient legally responsible for them") (emphasis added).

B. There is no evidence on the record that Wayne knew, or should have known, that its collection practices should have been disclosed on its claim submissions.

The trial court correctly recognized that regardless of the lawfulness of Wayne's collection practices, Health Net failed to prove that Wayne omitted a statement about its collection practices "knowing" that the omission of such a statement made its claims materially false or misleading. (Da 15.) The record provides no evidence that Wayne believed its collection practices were unlawful, a position endorsed by the trial court's similar conclusion. Indeed, Wayne was formally advised that it was legal for ASCs to not collect patient co-insurance under New Jersey law. (Pa 20-21, Simmons Cert. ¶ 10) (stating that when he joined Wayne as COO in 1999, Mr. Simmons spoke with attorneys, consultants and other ASCs, and they told him that it is perfectly legal not to collect co-insurance from patients and that it is standard practice in the ASC industry).

Health Net cites deposition statements made by Dr. Joseph Garcia, a Wayne surgeon owner, and Dennis Simmons, Wayne's Chief Operating Officer, to argue that Wayne waived co-insurance in

advance of treatment in order to induce patients to use Wayne's facilities. As a preliminary matter, Mr. Simmons, who is the only individual charged with making policy decisions on Wayne's collection practices, testified unequivocally that Wayne never promised patients that it would waive co-insurance.

> Q: Has the center ever told any patients that they would not be responsible for any portion of the charges which are unreimbursed by an insurance company?
>
> A: No.

(Pa 54, Simmons Dep. 63:3-7.)

Further, every Wayne surgeon owner with the exception of one said that he or she had no knowledge of Wayne's billing and insurance claim procedures, let alone that he or she discussed co-insurance with patients. (Pa 88, 91, 94, 100, 103, 106-107, 110, 113, 116, 120, Dr. Baratta Dep. 18:21-19:2, Dr. Calligaro Dep. 15:25-16:6, Dr. D'Anton Dep. 12:23-13:4, Dr. Doss Dep. 17:16-18:5, Dr. Ginsburg Dep. 22:13-23:6, Dr. Kearney Dep. 13:12-25, Dr. Matarese Dep. 18:18-19:2, Dr. Nicosia Dep. 19:19-25, Dr. Remsen Dep. 15:11-24, Dr. Schlecker Dep. 18:11-14.) The only physician who did say he discussed co-insurance with patients, Dr. Garcia, clearly did not use co-insurance waivers to promote referrals to Wayne. Viewing his testimony in the context of his entire deposition, Dr. Garcia specifically testified that he would not "guarantee" co-insurance write-offs,

and he told patients "they would have to discuss [co-insurance] with the surgery center and my staff would discuss it with Health Net and the surgery center and discuss that further with them." (Pa 54, Garcia Dep. 63:3-7.)

Thus, the deposition statements cited by Health Net reflect that Wayne and its surgeon owners did not make any promises to patients about co-insurance. Indeed, they are consistent with the entirety of the record, including testimony by Mr. Simmons that Wayne required patients to sign a document saying they remain legally obligated to pay all outstanding fees not covered by insurance. (Pa 53; Simmons Dep. 57:4-10.)

IV. The Court should not Address the Substance of the Trial Court's Analysis under the Codey Act because it is Unnecessary to Decide this Appeal; however, if the Court Decides to Address this Issue, it should Hold that the Trial Court Incorrectly Decided that Wayne's Ownership Structure Violates the Codey Act.

A. The trial court's Codey Act analysis is non-binding dicta, which should not be addressed.

The Codey Act, adopted in 1991 and modeled after the federal Stark law, 42 U.S.C. § 1395nn, provides that "[a] practitioner shall not refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, or the practitioner's immediate family, or the practitioner in combination with practitioner's immediate family has a significant beneficial interest." N.J. Stat. Ann. § 45:9-22.5. Unlike the Stark law, the Codey Act does not

expressly exclude ASC services from the prohibition on physician self-referrals. Nevertheless, physician-owned ASCs have developed rapidly in New Jersey since the adoption of the Codey Act, in large part because the BME, the state regulatory body charged with enforcing the Codey Act,[11] has taken the position that the Codey Act does not apply to physician owned ASCs.

In particular, the BME interpreted the Codey Act in a 1997 Advisory Opinion, in which it determined that a surgeon's referral of his or her own patients to an ASC is not an impermissible self-referral based on the Codey Act's exception for services provided in a physician's medical office. (Pa 173); see N.J. Stat. Ann. § 45:9-22.5(c)(1) (restrictions against self-referrals do not apply to "a health care service that is provided at the practitioner's medical office and for which the patient is billed directly by the practitioner"). The BME recognized that the "rationale for allowing a self-referral in [the physician-owned ASC] context is that the service offered is so integral to the practice of the surgeon that it may be perceived as an extension of his/her medical practice." (Pa 174.)

In the instant case, the trial court concluded that the plain language of the statute prohibited physicians from referring patients to ASCs. (Da 27.) The court held that based

[11] The Codey Act explicitly empowers the BME to "adopt rules and regulations necessary to carry out the purposes of this act." N.J.S.A. § 45:9-22.9.

on a technical reading of the Codey Act, physician-owned ASCs are not exempt from the self-referral prohibition merely because they are “an extension of the surgeon’s office." Id. The court found surgeries at Wayne were not performed at the surgeon’s “medical office,” and thus not exempt, because Wayne is a separate legal entity with separate billing practices and out-of-network claim submissions. Id.

Consideration of the trial court’s dicta is inappropriate in this case since both the Legislature and BME are working on legislation and regulations that would clarify that surgeon-owned ASCs such as Wayne do not violate the Codey Act. Following the trial court’s decision in this case, the BME pursued emergency rulemaking in order to clarify that the Codey Act does not apply to ASCs that are “an extension of a practitioner’s medical office” based on meeting certain regulatory conditions. (Pa 757-761, BME Draft Emergency Rule.)

Furthermore, the New Jersey State Legislature, led by Senate President Richard J. Codey (the principal author and sponsor of this namesake statute) and Assembly Chairman Conaway, initiated legislation (S-787 and A-1933) that would allow physicians to make referrals to physician-owned ASCs in certain circumstances. (Pa 762, Senate Substitute for S-787.) If enacted, the Codey Bill would clarify the law to expressly exempt existing ASCs and certain ASCs in development from the

Codey Act's physician self-referral prohibition, and further clarify that prior referrals to these ASCs to be compliant (such as the referrals to Wayne at issue in this case). Id.

B. The trial court erroneously concluded that Wayne's physician-ownership structure violates the Codey Act.

Despite the obvious legislative and regulatory movement toward expressly authorizing physician-owned ASCs and the fact that the BME has taken no steps toward enforcing the Codey Act against ASCs, if the Court were to endorse the trial court's Codey Act analysis, insurers could bring future insurance fraud actions against physician-owned ASCs arguing that the "knowing" element of the IFPA is satisfied because this case puts ASCs in New Jersey on notice that physician-owned ASCs are prohibited. Accordingly, if the Court addresses the trial court's Codey Act analysis, it is imperative that the Court reverse its erroneous conclusion.

Although the Codey Act is ambiguous as to what constitutes a "medical office," the trial court's analysis leads to obvious interpretational inconsistencies. The trial court allowed that "[i]f the doctor performed the 'health care service' (e.g., the surgical procedure) at her own medical office, and billed the patient directly for it," that arrangement would not violate the Codey Act ban on self-referrals. See N.J. Stat. Ann. 45:9-22.5(c)(1) (providing a statutory exception to self referral

prohibition for doctors who perform such procedures in their "own medical office and bill the client directly for it"). Presumably, under this interpretation, as long as doctors designate an office as their "medical office" and bill patients and submit claims from that office, they would not violate the Codey Act, even though the incentive for self-referral would be at least equivalent (and arguably greater than) if they performed the surgery at an ASC such as Wayne.

In this case, the trial court should have deferred to the BME, the regulatory body that the Legislature empowered to enforce the Codey Act. See New Jersey Hosp. Ass'n v. Fishman, 278 N.J. Super. 469, 473 (App. Div. 1995) (recognizing that courts should "give substantial deference to the interpretation of the agency charged with enforcing an act," and that "[t]he agency's interpretation will prevail provided it is not plainly unreasonable"). New Jersey courts "extend particularly strong deference to an administrative construction of a statute that is long-standing," such as the BME's 1997 Advisory Opinion, given that the "practical administrative construction of a statute over a period of years without interference by the legislature is evidence of its conformity with legislative intent." Township of Dover v. Scuorzo, 392 N.J. Super. 466, 476 (App. Div. 2007).

The BME clearly did not interpret the Codey Act as did the trial court, which is apparent because the physician-owned ASC structure is "ubiquitous" in New Jersey. (Da 29.) (stating that "the very ubiquitousness of physician-owned ambulatory surgical centers, receiving referrals from physician investors, is proof positive that this mechanism for delivering healthcare to the public is serving a need"). Indeed, the only time the BME had the opportunity to address physician-owned ASCs, the BME held that it does not deem "a surgeon's referral of his or her own patient to an ASC in which he has an interest an impermissible self-referral." (Pa 173-175.) Specifically, the BME said that its "rationale for allowing a self-referral in [the ASC] context is that the service offered is so integral to the practice of the surgeon that it may be perceived as an extension of his/her medical office practice." (Pa 174.) Thus, the BME's Codey Act inquiry focuses on whether the ASC is "integral to the surgeon's practice," and not on superficial factors such as ASC office location and whether the ASC is a separate billing entity.

The BME's interpretation finds support in numerous compelling policy reasons for allowing physician-owned ASCs, many of which were expressly recognized by the trial court. First, the physician-owned ASC model allows practitioners to refer patients to the facility that he or she knows has the best and most expedient care. The trial court found substantial

evidence that physician-owned ASCs provide advantages of physician control over the level of care and efficiency. (Da 28-29.) (stating that "important considerations of efficiency and convenience are served by having appropriate surgical candidates undergo their necessary procedures in a Center owned in part by the patient's physician, as opposed to having the exact same necessary procedure performed in a hospital").

Second, as the trial court recognized, the record contains no evidence that surgeon referrals to ASCs in which they own an interest are motivated by financial incentives, as opposed to sound medical decision-making.

> The absence of any evidence that this surgical center-or any other New Jersey physician-owned ambulatory surgical center-has perpetrated what the Act was designed to blunt (unnecessary health care services, or medical judgment impacted by financial incentives) is further evidence that beneficial public objectives may be achievable though legislative tolerance of this sort of mechanism for delivering health care services.

(Da 29.) In this case, there is substantial evidence that Wayne's surgeon owners formed Wayne in order to provide their patients with the benefits of a superior surgical facility. (Pa 84, 87, 91, 94, 100, 106, 116, Dr. Baratta Dep. 17:2-25, Dr. D'Anton Dep. 9:15-10:13, Dr. Ginsburg Dep. 21:14-22:12, Dr. Kitrosser Dep. 11:19-12:9, Dr. Matarese Dep. 12:9-24, Dr. Nicosia Dep. 18:2-19, Dr. Schlecker Dep. 17:20-18:10.)

Third, the State has allowed practitioners to develop and own these facilities, and it is not clear who will purchase and run the facilities once this ownership structure has been eliminated. Thus, a per se prohibition on physician-owned ASCs would have a detrimental impact on the medical community because it would deprive doctors and patients of the valuable treatment options provided by physician-owned ASCs. Accordingly, the trial court should have deferred to the BME's interpretation that physician-owned ASCs such as Wayne are legal under the Codey Act.

CONCLUSION

For the foregoing reasons, we respectfully submit that the Appellate Division should dismiss this Appeal and affirm the trial court's decision. In the event the Appellate Division decides to address the legality of Wayne's surgeon ownership structure under the Codey Act, we respectfully submit that the Appellate Division should reverse this aspect of the trial court's ruling.

Respectfully submitted,

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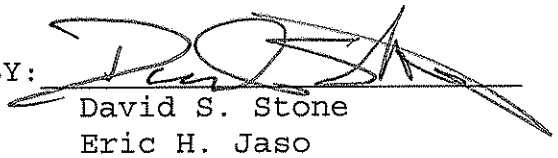
BY: 
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