THE FLORIDA BAR
BOARD OF LEGAL SPECIALIZATION AND EDUCATION

HEALTH LAW
BOARD CERTIFICATION EXAMINATION

Example Multiple Choice & Essay Questions

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Multiple Choice

1. Dr. Spring is a Florida Medicaid Provider who treats Medicaid patients for asthma. Most asthma medications require nebulizers. Spring also has an ownership interest in a Durable Medical Equipment company ("DME"), which is also a Medicaid Provider. Spring has decided to store nebulizers at her physician office for the convenience of her patients, and Spring's staff will distribute the nebulizers to the patients. Spring has contracted with DME to supply the nebulizers. DME will submit Medicaid claims for the nebulizers when distributed by Spring to Medicaid patients. Spring will receive no reimbursement from Medicaid for distributing the nebulizers. For dates of service after January 1, 2009, will Medicaid pay DME for nebulizers furnished under this arrangement?

    a. Yes, because the nebulizers are being provided as a courtesy for the patients of Dr. Spring's practice and the arrangement presents minimal risk for program fraud and/or abuse.

    b. No, because the nebulizers are not being directly furnished by the DME company and subcontracting or consignment of the service or supply to a third party is prohibited.

    c. Yes, so long as Dr. Spring documents the medical necessity and the DME company provides and documents training to the physician's staff who will distribute the nebulizers.

    d. No, because there is a financial relationship between Dr. Spring and the Medicaid Durable Medical Equipment provider.

Answer: D

2. Due to the high costs of medical malpractice insurance, a group of neurosurgeons has determined that it would like to form its own captive insurance company. The captive insurance company will be organized in Bermuda and will qualify as an insurance company under the laws of Bermuda. The captive insurance company will not be licensed or authorized to do business in the state of Florida.

The captive insurance company will issue medical malpractice insurance policies to each of the neurosurgeons for professional liability insurance with coverage limits of $250,000.00 per claim and $750,000.00 annual aggregate.

Each of the neurosurgeons will satisfy their financial responsibility requirements to maintain their licenses to practice medicine under Florida law as long as:

a. the medical malpractice insurance policies from the captive insurance company provide the minimum professional liability coverage requirements allowed under Florida law.

b. the captive insurance company arrangement qualifies as a risk retention group under Florida law.

c. the captive insurance company arrangement qualifies as a plan of self-insurance under Florida law.

d. each neurosurgeon establishes and maintains an escrow account or irrevocable letter of credit that satisfies the financial responsibility requirement under Florida law; or, in the alternative each neurosurgeon satisfies the requirements for going "bare" under Florida law, including posting a prominently displayed notice in the form of a sign in their reception area stating they have decided not to carry medical malpractice insurance.

Answer: D

3. If a Medicare carrier assesses an overpayment against a physician and the physician timely appeals the assessment, when can the carrier begin recouping the overpayment from the physician's current payments?

   a. Never. The carrier is not authorized to withhold current payments to recoup an overpayment resulting from past services.

   b. 30 days from the date of the overpayment demand letter.

   c. At any time upon prior written authorization from the Centers for Medicare & Medicaid Services.

   d. After the reconsideration decision is rendered by the qualified independent contractor.

Answer: D

4. Patient executes a valid living will in the form suggested under Florida state law. Patient designates her oldest son, Steve, as her surrogate to carry out the provisions of her living will. In her living will she directs that life prolonging procedures be withheld and that she be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or alleviate pain. Patient is terminally ill and lacks the capacity to make her own health care decision. Physicians recommend that for hydration and sustenance a naso-gastric tube ("tube") be inserted since they estimate she has 3 more months left to live. Ben, patient's youngest son, authorizes the insertion of the tube. However, Steve does not want the tube inserted. Florida law requires the hospital to:

   a. not insert the tube and let the patient die without hydration and sustenance.

   b. insert tube since it is not a life prolonging procedure.

   c. wait at least 7 days before making a decision.

   d. convince Steve to authorize the insertion of the tube.

Answer: A

5. Under the recruitment exception to Stark, which of the following is correct?

   a. A hospital cannot use different zip code configurations to define the geographic area served by the hospital for different recruitment arrangements.

   b. There are two tests to meet the relocation requirement: (i) the recruited physician must move his/her medical practice from outside to inside the geographic area served by the hospital, and (ii) the recruited physician must either (a) move his/her medical practice a minimum distance of twenty-five miles or (b) derive at least seventy-five percent of his/her practice revenues from services provided to new patients.

   c. An existing medical practice into which a physician is recruited is permitted to allocate to the recruited physician up to 25% of the practice's aggregate overhead and other expenses if the recruited physician is replacing a deceased, retiring or relocating physician in a rural area or HPSA.

   d. The recruited physician may sign a one-page acknowledgement agreeing to be bound by the terms of the recruitment agreement executed by the hospital and the physician practice.

Answer: B

6. Tom Jones, M.D., has decided to relocate his practice from the medical office in which he shares space with four other physicians. Under Florida's regulations governing the practice of medicine, Dr. Jones is required to:

a. send an announcement to his current patients informing them of the move.

b. publish a notice of his relocation once each week for four consecutive weeks in a local newspaper that serves his practice area.

c. transfer the medical records of his former patients to one of the physicians at his old office, in a transaction that meets the requirements of Florida's statute governing the ownership and control of patient records.

d. place a sign in a conspicuous location outside of his former office advising his patients of their opportunity to transfer or receive their medical records and send an announcement to his current patients informing them of the move.

Answer: B

7. The Care Group, P.A. (“Care”), is enrolled in Florida’s Medicaid Program as a fee-for-service provider. One of Care’s physician shareholders was convicted of a criminal offense related to the delivery of health care. The criminal offense and conviction occurred after July 1, 2009. Regarding participation in the Medicaid program, and under current Florida law, the Agency for Health Care Administration must:

   a. terminate Care’s participation in the Medicaid Program, unless it had an effective self-disclosure program.

   b. terminate Care’s participation in the Medicaid Program if the convicted physician shareholder had an ownership interest in Care equal to 5 percent or greater, unless the agency determines that Care did not participate or acquiesce in the offense.

   c. terminate the physician shareholder from participation in the Medicaid Program, but is not required to terminate Care's participation in the Medicaid Program.

   d. terminate Care’s participation in the Medicaid Program, but only if a Medicaid recipient was neglected or physically abused in connection with the criminal activity.

Answer: B

8. Nancy is an osteopath who is the sole owner of Celebrity Images, LLC, a facility that provides cosmetic procedures such as Botox injections, face lifts and others. Nancy has recently been engaged to Arthur, who is a CPA. They decide that, once they are married, Arthur will become a 45 percent shareholder in Celebrity Images, LLC and will be employed as a business manager. When they are married, they will need to:

   a. Apply for a health care clinic license because Arthur is not a "health care practitioner."

   b. Apply for a new Medicare provider number.

   c. Do nothing unless the facility only accepts cash payments.

   d. Nothing because they are exempt from needing a health care clinic license.

Answer: D

9. Under the Patients' Rights Rules governing participation in federal reimbursement programs, hospitals must report:

   a. Any patient death that occurs while the patient is restrained or in seclusion.

   b. Any patient death occurring within one week after the use of restraints or seclusion has been discontinued.

   c. Only patient deaths that occur while a patient is restrained for behavior management.

   d. Any patient injury related to the use of restraints for behavior management.

Answer: A

10. County Medical Center is a statutory rural hospital located in Florida, and is operated by Regional Health System. County Medical Center's facilities are outdated and in need of repair, and Regional Health System would like to tear down County Medical Center and replace it with a new facility. Would such project require a Certificate of Need ("CON")?

    a. Yes, the project would require a CON and would qualify for expedited review.

    b. Yes, the project would require a CON, but would NOT quality for an expedited review.

    c. No, as long as the replacement facility is located within one mile of the old facility and the number of beds does not increase it would not require a CON.

    d. No, as long as the replacement facility is located within ten miles of the old facility it would not require a CON.

Answer: D

11. Dr. Jones is an employed physician of Medical Group. He is not an owner of Medical Group. Medical Group assigned Dr. Jones to provide part-time (less than 32.5 hours per week) obstetric and gynecological services to Community Health Center, a federally qualified rural health clinic, receiving funding pursuant to Section 330 of the Public Health Service Act (the "Center"). Dr Jones provides such services pursuant to a professional services agreement between the Center and Medical Group. Dr Jones has been deemed an employee of the Public Health Service by the Secretary of Health and Human Services for purposes of Federal Tort Claims Act ("FTCA") coverage and is therefore eligible for such coverage. Is Dr. Jones a "covered individual" for purposes of FTCA coverage?

    a. No, because there is no direct contractual relationship between Dr. Jones and the Center.

    b. Yes, because Dr. Jones is employed by a medical group which contracted with the Center.

    c. No, because only the center's employees are considered "covered individuals."

    d. Yes, because obstetric and gynecological services are not required to be provided on a full-time basis in order to be covered under the FTCA.

Answer: A

12. The Patient Protection and Affordable Care Act of 2010 (PPACA) sets forth several changes applicable to nonprofit hospitals which are exempt under Section 501(c)(3) of the Internal Revenue Code. The changes include all of the following **EXCEPT:**

a. new eligibility requirements for 501(c)(3) hospitals to maintain exemptions, plus an excise tax for failure to meet certain requirements.

b. new hospital reporting requirements regarding community health needs assessments and audited financial statements.

c. mandatory and ongoing review by the IRS of hospitals' entitlement to exemption under 501(c)(3).

d. mandatory enhanced and extraordinary collection efforts, even if patients may be eligible for assistance under the hospital's financial assistance policy.

Answer: D

13. St. Beth's Hospital ("SBH") consults with you, as legal counsel, seeking advice regarding possible hospital/physician integration strategies. SBH now desires to pursue a physician practice acquisition strategy through which it will acquire a 30% equity interest in a medical practice. The practice consists of multiple owners and employees specializing in either medical oncology or radiation oncology. As part of the arrangement, physician owners will be making self-referrals to the practice. In advance of the transaction, SBH would like to obtain a declaratory statement from AHCA, confirming that the contemplated arrangement does not violate Florida's Patient Self-Referral Act of 1992, § 456.053 Fla. Stat. (2010).

Which of the following answers correctly states the law?

a. SBH may not seek a declaratory statement from AHCA because Florida's Patient Self-Referral Act of 1992 falls within the Chapters governing licensed health care professionals and therefore any declaratory statement must be obtained from the Florida Board of Medicine.

b. A declaratory statement is not an available remedy.

c. The hospital may seek a declaratory statement from AHCA, only after the hospital obtains a legal compliance assessment, which must be attached, as supplemental evidence, to the hospital's request for the declaratory statement.

d. The hospital may seek a declaratory statement from AHCA.

Answer: D

14. Dr. A has developed an excellent international reputation in his field of specialization and is seeing increasing numbers of foreign patients who travel to Florida exclusively to see him. Many of these patients have health coverage based in their country of origin, and it is difficult to process and collect payment from these foreign payors. Dr. A has been approached by Mr. B, who has developed a business of facilitating claims processing and collection for international payors, and may be able to get Dr. A designated as a preferred provider with some of the payors. Mr. B proposes a contract wherein Dr. A would pay him 20 percent of each foreign payor claim that Mr. B is able to collect on behalf of Dr. A, plus $100 for each new patient Dr. A is able to see in his office as a preferred provider. May Dr. A legally enter into such an agreement?

a. Yes, provided the new patients do not qualify as eligible for alien Medicaid coverage in Florida and no claims are submitted to a federal healthcare program for their care.

b. No, as the proposed payment relationship violates Florida law.

c. No, as the proposed payment relationship implicates the Foreign Corrupt Practices Act.

d. Yes, provided the payment amounts are set in advance and do not vary based on the value or volume of referrals.

Answer: B

Example Fraud & Abuse Essay

General Facts (applicable to all questions):

Florida Anesthesia Group, P.C., an anesthesiology group practice ("Group"), entered into a written contract with Pelican Bay Hospital ("Hospital), for providing anesthesiology services at Hospital. Under the contract ("Anesthesiology Agreement"), Hospital provided office space, supplies, equipment and personnel for Group's use when providing anesthesiology services to patients at Hospital. Hospital also granted Group the exclusive right to provide anesthesiology services to Hospital. Pain management services were also referenced in the Anesthesiology Agreement; however, at the time of the Anesthesiology Agreement, neither Group nor Hospital provided pain management services, nor did Hospital own or operate any provider-based or free-standing facility for the provision of pain management services. Hospital and Group each billed Medicare and Medicaid for their respective anesthesiology services.

Approximately two years later, Hospital built a stand-alone outpatient ambulatory surgical center ("ASC") and a pain clinic ("Pain Clinic"), located about 3 miles from Hospital. From the time the new facilities opened, Group provided pain management services ("Pain Management Arrangement") to patients in the Pain Clinic, ASC and Hospital. In exchange, Group was given rent-free space and equipment at Pain Clinic, and also provided with utilities, supplies and support personnel at no charge. As with the anesthesia services, Group physicians submitted claims to Medicare and Medicaid for the professional services performed during the pain management services, and Hospital submitted claims for the facility and technical components of the services. The parties did not amend the Anesthesiology Agreement to include the additional facilities or new range of services and responsibilities, nor did the parties enter into a new contract for the Pain Management Arrangement.

With Group's expansion into pain management, it was now in a position to accept referrals, make referrals, establish plans of care, and direct patient care. Under the Pain Management Arrangement, patients presenting to Group inside Pain Clinic are evaluated by a Group physician and given prescriptions for interventional procedures such as injections or other treatments. Such injections and treatments are performed in a space separate and apart from that in which Group physicians perform their evaluation and management services. Patients recommended for injections and other interventional procedures are referred by Group physicians to Hospital, ASC or

Pain Clinic. Following the referral, Group physicians routinely provide the professional component of the interventional procedure ordered. Most, but not all, of the pain management services are provided on an outpatient basis.

Question 1.

For purposes of Questions One and Two, assume you are an attorney in private practice. Consider the following additional facts which are applicable to Question One:

Tom Teller, M.D., a former physician member of Group, has consulted you for advice and/or representation. While still a member of Group, Dr. Teller became concerned that Group was not paying or being charged any rent for equipment, space and personnel or charges for other items being provided by Hospital including ASC and Pain Clinic. He discussed this concern with his Group members and the CEO of Hospital. He was told to keep his mouth shut.

a. Discuss whether the parties' arrangements implicate the Stark law, Federal Anti-kickback law, or the Florida self-referral and anti-kickback laws.

b. Should you determine that any of these laws are implicated, discuss whether any exceptions or safe harbors would apply to the parties' arrangements. Should you determine that one or more exceptions or safe harbors apply, discuss the elements of the exception or safe harbor and explain its application to the facts.

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Question 2.

For purposes of Question Two only, consider the following additional facts:

Dr. Teller alleged that his former Group, and Hospital, ASC and Pain Clinic certified compliance with all relevant laws when submitting claims to Medicare and Medicaid. Dr. Teller wants to file a false claim act action against Group and Hospital, ASC and Pain Clinic.

a. Discuss whether a violation of the Stark law and/or Federal anti-kickback statute could be used as the basis for a Federal False Claims Act cause-of-action. If you determine that a FCA action is possible, present an argument which analyzes both the strengths and weaknesses of a possible FCA action, to include potential penalties. Also include a discussion of Florida False Claims laws as may be applicable.

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Question 3.

For purposes of Question Three only, assume you are the In-House General Counsel for Hospital, ASC, and Pain Clinic. Consider the following additional facts which are applicable to Question Three only:

Hospital received an anonymous complaint alleging that the Pain Management Arrangement was not in legal compliance and the parties were submitting false claims.

In response, Hospital conducted an internal investigation and claims audit. It was discovered that facet joint injections were performed disproportionately to other interventional procedures performed. (Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain).

Hospital discovered that a substantial number of unilateral injections performed on one side of the joint level were incorrectly billed as bilateral injections (i.e., right and left side of the joint level). The coding for bilateral injections resulted in nearly double the reimbursement for claims submitted to Medicare and Medicaid. It was also discovered that: (1) many of the facet joint injections did not have documentation to support their medical necessity; (2) many of the facet joint injections were not covered by the applicable government payer; and (3) some of the injection services could not be documented as having ever been performed.

Hospital (including ASC and Pain Clinic) has consulted you for legal advice.

a. Identify and analyze the fraud and abuse issues arising from the findings of the internal investigation and claims audit.

During the internal investigation and claims audit, it could not be determined if laws were violated with intent to defraud the government, or if the actions were unintentional billing errors or poor management. However, Hospital, ASC and Pain Clinic seem to be leaning toward not disclosing the matter and retaining the reimbursements.

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b. Under what legal obligations and/or established duties, if any, must the parties self-disclose their findings. Also, discuss and analyze the parties' potential liability, relative to obligations to repay overpayments, or for the retention of overpayments. Include a discussion of relevant Federal and State laws and participation in Medicare, Medicaid, and other government health care programs.

c. Discuss the potential benefits and risks of a self-disclosure to the government, and describe how you would advise your client to proceed. If you advise your client to self-disclose, describe what information you would recommend be disclosed and to whom.

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Question 4.

For purposes of Question Four [only], assume you are an attorney in private practice. In the past, your firm represented members of Group, including Tom Teller, M.D., Hospital, and more recently ASC and Pain Clinic.

You have been consulted by Hospital's General Counsel ("GC"), who is seeking personal legal advice. Consider the following additional facts which are applicable to Question Four, including information provided by GC:

Dr. Teller recently told GC that Dr. Teller has evidence that the parties conspired to violate laws to increase patient referrals for pain management services and bill false and fraudulent claims. Dr. Teller asked GC to hold the information confidential because Dr. Teller is pursuing a whistle-blower law suit against, in his words, the "fraudsters." He also gave GC some friendly advice to "protect yourself – this could get nasty."

On numerous occasions, GC advised Hospital that the Pain Management Arrangement and attendant claims were potentially problematic, and that the arrangement should be immediately modified. GC's advice was not taken and when GC subsequently discussed the matter with Hospital's Chief of Staff, GC was reminded that Hospital, ASC and Pain Clinic were in the red and cut-backs were under consideration, to include GC's Office. GC is fearful of retaliation if he discloses these matters to Hospital's governing board. He is also fearful that he may be subject to personal liability should the government pursue a fraud action against the parties.

a. Identify and discuss your ethical duties under the Rules of Professional Conduct and whether you may render legal advice to GC. Should you decide to render any advice to GC, explain the advice you would offer.

b. Identify and discuss GC's obligations under the Rules of Professional Conduct, to include actions GC may take and actions GC must take.

Example Provider Regulatory Matters Essay

General Facts (applicable to all questions):

Hospitalists-R-Us ("HRU") is a three-physician group of hospitalists that provides services under an exclusive agreement to a regional acute care hospital system in central Florida. The three physicians each have a 1/3 ownership interest in the group. One of the physicians, Dr. Red, calls you to discuss an issue he is having in Georgia, where he is also licensed. He tells you that, in 2000, he was the medical director in Atlanta for a clinic that was providing HIV infusion medications to patients, some of whom were Medicaid recipients. The state attorney's office in Georgia investigated the matter and determined that many of these patients either did not qualify for, or did not receive, the expensive infusion medications that were billed to the Georgia Medicaid program. Dr. Red was charged in a multiple-count criminal complaint alleging insurance fraud and grand theft, among other violations. He has been offered a plea deal by the assistant state attorney that would result in a misdemeanor conviction on one count of insurance fraud. Dr. Red has not discussed this yet with his partners at HRU. He would like your advice concerning the impact of the plea on his Florida physician's license.

Question 1. What does Dr. Red need to consider in deciding to accept or reject the assistant state attorney's offer?

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One of Dr. Red's partners, Dr. Green, would also like to retain you to represent him in connection with another matter. Ten months ago, Dr. Green prescribed a medication for a hospital patient, Jennifer, who had an allergic reaction to the medication. Jennifer's chart did not indicate that she was allergic to the medication, but Jennifer says she told Dr. Green that she was allergic to the medication when he first examined her. She became severely ill and spent several days thereafter in the intensive care unit until she was stabilized. Jennifer's family reported the matter to the Department of Health. A few months ago Dr. Green received a letter from the Department of Health concerning the matter. Dr. Green believes the letter required him to respond within a specific time frame and thought he had kept the letter but was unable to find it. Dr. Greene confides in you that he already has two judgments against him from separate malpractice incidents in the past, so he would like to resolve this incident as quickly and quietly as possible.

Question 2. How would you represent Dr. Green? What recommendations would you make to Dr. Green concerning this matter?

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Dr. Green receives an Administrative Complaint from the Department of Health charging him with a standard of care violation and a medical records violation. Dr. Green elects to proceed to a formal administrative hearing to prove his innocence. Jennifer, who lives in New York, did not appear to testify. Her sister, however, lives locally and did appear at the hearing. The sister testified that Jennifer told her on multiple occasions, both before and after the incident that she had told Dr. Green about her allergy to the medication. A staff nurse also testified that Jennifer had told her, after she was released from intensive care, that she had discussed her allergy with Dr. Green. The hospital's records custodian testified that the hospital's records do not mention Jennifer's allergy. The hospital admissions clerk who met with Jennifer upon her admission to the hospital testified that she did not remember whether or not Jennifer mentioned her allergy. No additional witnesses testified at the hearing.

Question 3. Discuss the arguments to be raised in your proposed recommended order on behalf of Dr. Green with respect to this testimony.

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HRU is in negotiations with Practice Management Associates ("PMA") and would like to contract with them to provide practice management services. Under the proposed agreement, PMA would provide a menu of services at a flat monthly rate, and in addition would be paid a quarterly performance fee of 5% of total profits as an incentive for PMA to increase revenue. They ask you to look into this arrangement.

Question 4. Do you have any concerns over the proposed agreement? If so, what are HRU's options?

Assume for this question that you have represented the hospital system as outside counsel in litigation matters for many years and that you continue to provide such representation. The agreement between HRU and hospital is up for renewal in a few months and Dr. Red, the physician who has the pending plea deal in Georgia, has approached you requesting your assistance in helping negotiate and draft an agreement. Dr. Red tells you that HRU has recently requested economic support from the hospital since a large number of patients seen at the hospital are indigent patients and the group is finding it increasingly difficult to continue to provide services for the hospital system with no economic support from the hospital. In your discussion with Dr. Red you inform him that while you have handled many litigation matters in the past for the hospital and have represented many physicians in licensure matters that you have never worked on a transactional matter of this type. Dr. Red insists on your representation of HRU and strongly believes that you are the person for the job particularly since you have strong ties with the system's CEO and other members of the system's 'A' Team as a result of the many years of loyal and continuing service to the hospital system. You are very happy that after discussing the matter with the hospital system's CEO you have gotten the CEO to verbally agree to split your legal fees with HRU because the CEO believes that your involvement in this transaction will save the hospital system from having to pay another lawyer's legal fees.

Question 5. Discuss whether you would represent HRU in this transaction and any ethical concerns over such representation.