Maryland Health Occupations Article, § 14-404(a)(15) (Maryland Physician Fee-Splitting Statute)
Permits the Maryland Board of Physicians to reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the licensee pays or agrees to pay any sum to any person for bringing or referring a patient or accepts or agrees to accept any sum from any person for bringing or referring a patient.

83 Opinions of the Attorney General 142 (1998)
A hospital’s purchase, through its corporate affiliate, of a professional medical corporation owned by physicians at a purchase price determined by an appraisal by an outside consultant based on the revenue historically generated by each of the corporation’s physicians at the professional medical corporation over a set period of time does not appear to involve any payments based on a percentage of earnings by the physicians after the sale, and therefore does not implicate the Maryland fee-splitting statute.

There are circumstances in which the sale of a physician practice can amount to fee splitting (e.g., the sale of a practice by one physician or group of physicians to another for a percentage of the future income of the practice over a period of years).

Where a physician or practice pays a set percentage of the physician’s or practice’s professional fees to a separate entity for services provided by that entity to the physician’s or practice’s patients, the Maryland fee-splitting statute requires that the percentage charged must reasonably reflect the value of the services provided to patients in the aggregate, not on a patient-by-patient basis. That aggregate may
include some patients on whose behalf no services are provided, but the inclusion of a large, identifiable group of such patients would raise fee-splitting problems.

**Maryland Criminal Law Article, §§ 8-508, 8-511 through 8-512, 8-516 through 8-517 (Medicaid Fraud)**

Defines “false representation,” “health care services,” “representation,” “serious injury,” and “State health plan.” Applies to the Maryland Medicaid program; insurers, health maintenance organizations (HMOs), managed care organizations (MCOs), health care cooperatives or alliances, or other persons that provide or contract with the Medicaid program to provide health care services reimbursable by the Medicaid program; and their subcontractors (each a “State health plan”).

Prohibits a person who provides to another individual items or services for which payment is or may be made, wholly or partly, from federal or State funds under a State health plan, from soliciting, offering, making, or receiving a kickback or bribe in connection with providing those items or services or making or receiving a benefit or payment under a State health plan.

Prohibits a person from soliciting, offering, making, or receiving a rebate of a fee or charge for referring another individual to a third person to provide items or services for which payment wholly or partly is or may be made from federal or State funds under a State health plan.

Provides for the following criminal penalties:

1. A violation resulting in the death of an individual constitutes a felony subjecting a convicted offender to imprisonment not exceeding life, or a fine not exceeding $200,000, or both;
2. A violation resulting in serious injury to an individual constitutes a felony subjecting a convicted offender to imprisonment not exceeding 20 years, or a fine not exceeding $100,000, or both;
3. A violation involving money, health care services, or other goods or services worth $1,500 or more in the aggregate constitutes a felony subjecting a convicted offender to imprisonment not exceeding five years, or a fine not exceeding $100,000, or both;
4. Any other violation constitutes a misdemeanor subjecting a convicted offender to imprisonment not exceeding three years, or a fine not exceeding $50,000, or both; and
5. An association, firm, institution, partnership, or corporation violating this statute is subject to a fine not exceeding $250,000 for each felony and $100,000 for each misdemeanor.

Provides for civil penalties in an amount not more than three times the amount of the overpayment, in addition to any other penalty provided by law and any right the victim may have to restitution under the Maryland Criminal Procedure Article.
**Maryland Health Occupations Article, § 2-314(23) (Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists)**
Permits the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists to deny a license or limited license to any applicant, reprimand any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, or suspend or revoke a license or limited license if the applicant, licensee, or holder pays or agrees to pay any sum to any person for bringing or referring a patient.

**Maryland Health Occupations Article, § 3-313(15) (Chiropractors)**
Permits the Maryland Board of Chiropractic Examiners to deny a license to any applicant, reprimand any licensee, place any licensee on probation, with or without conditions, or suspend or revoke a license, or any combination thereof, if the applicant or licensee pays or agrees to pay any sum to any person for bringing or referring a patient.

**Maryland Health Occupations Article, § 11-313(13) (Optometrists)**
Permits the Maryland Board of Examiners in Optometry to deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee splits or agrees to split a fee for optometric services with any person for bringing or referring a patient.

**Maryland Health Occupations Article, § 12-313(b)(12) (Pharmacists)**
Permits the Maryland Board of Pharmacy to deny a license to any applicant for a pharmacist's license, reprimand any licensee, place any licensee on probation, or suspend or revoke a license of a pharmacist if the applicant or licensee provides remuneration to an authorized prescriber for referring an individual to a pharmacist or pharmacy for a product or service to be provided by that pharmacist or pharmacy.

**Maryland Health Occupations Article, § 13-316(9) (Physical Therapists)**
Permits the Maryland Board of Physical Therapy Examiners to deny a license or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee, or holder pays or agrees to pay any sum to any person for bringing or referring a patient.

**Maryland Health Occupations Article, § 16-311(a)(14) (Podiatrists)**
Permits the Maryland Board of Podiatric Medical Examiners to deny a license or a limited license to any applicant, reprimand any licensee or holder of a limited license, impose an administrative monetary penalty not exceeding $50,000 on any licensee or holder of a limited license, place any licensee or holder of a limited license on probation, or suspend or revoke a license or a limited license if the applicant, licensee, or holder pays or agrees to pay any sum to any person for bringing or referring a patient.
2) PROHIBITIONS ON SELF-REFERRAL


Prohibits any physician or other health care practitioner licensed under the Maryland Health Occupations Article from referring a patient, or directing an employee or contractor of the practitioner to refer a patient, to a health care entity if any of the following is true, unless the beneficial interest or compensation arrangement meets a specific exemption in the statute: (1) the practitioner or the practitioner in combination with his or her immediate family owns a beneficial interest in the health care entity; or (2) the practitioner’s immediate family owns a beneficial interest of 3% or greater in the health care entity; or (3) the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement with the health care entity.

Prohibits a health care entity or a referring health care practitioner from presenting or causing to be presented to any individual, third-party payor, or other person a claim, bill, or other demand for payment for health care services provided as a result of a prohibited referral.

Prohibits any arrangement or scheme, including a cross-referral arrangement, which the health care practitioner knows or should know has a principal purpose of assuring indirect referrals that would be in violation of the statute if made directly.

Defines “beneficial interest,” “compensation arrangement,” “direct supervision,” “faculty practice plan,” “group practice,” “health care entity,” “health care service,” “health care practitioner,” “immediate family member,” “in-office ancillary services,” and “referral.”

Definition of a “beneficial interest” excludes ownership of certain types of securities meeting defined criteria (e.g., publicly traded).

Definition of “compensation arrangement” excludes certain types of arrangements meeting defined criteria (e.g., bona fide employment agreement, faculty practice plan, independent contractor arrangement, practitioner recruitment agreement, space or equipment lease, and sale of property or a health care practice).

(Additional definitions are contained in the Code of Maryland Regulations (COMAR) 10.01.15.02, discussed below.)

Defines “in-office ancillary services” as expressly excluding magnetic resonance imaging (MRI), radiation therapy, and computed tomography (CT) scan services for all physician groups or offices except for a radiologist group practice or an office consisting solely of one or more radiologists, effectively limiting the availability of the in-office ancillary services exemption for these services exclusively to radiology practices. Maryland Attorney General opinions and a Declaratory Ruling by the Maryland Board of Physicians (discussed further below) have interpreted two other
statutory exemptions without an express MRI/radiation therapy/CT carve out (group practice exemption [§ 1-302(d)(2)] and direct supervision exemption [§ 1-302(d)(3)]) as being unavailable to non-radiology medical practices wishing to provide MRI, radiation therapy, and CT scan services directly to their patients.

Provides certain specific exemptions from the self-referral prohibition, including:

- Treatment of an HMO member if the health care practitioner doesn’t have a beneficial interest in the health care entity.
- In-office ancillary services exemption similar to federal Stark exception. (See discussion below of Maryland Board of Physicians Declaratory Ruling 2006-2 for interpretation of this exemption.)
- Referral to another practitioner in the same group practice. (See discussion below of Maryland Board of Physicians Declaratory Ruling 2006-1 and Maryland Board of Physicians Declaratory Ruling 2006-2 for interpretation of this exemption.)
- Referral for health care services or tests performed personally by or under direct supervision of the referring practitioner. (See discussion below of Maryland Board of Physicians Declaratory Ruling 2006-1 and Maryland Board of Physicians Declaratory Ruling 2006-2 for interpretation of this exemption.)
- A health care practitioner who has a beneficial interest in a health care entity if, under Department of Health regulations, the Secretary determines that “the health care practitioner’s beneficial interest is essential to finance and to provide the health care entity” and “the health care entity is needed to ensure appropriate access for the community to the services provided at the health care entity.”
- Referral by a health care practitioner employed by or affiliated with a hospital to an entity owned or controlled by the hospital (or under common ownership or control) if the health care practitioner doesn’t have a direct beneficial interest in the health care entity.
- Health care services provided by a health care practitioner or member of a single specialty group practice (including any person employed or affiliated with a hospital) who has a beneficial interest in a health care entity owned or controlled by a hospital (or under common ownership or control with a hospital) if (i) “the health care practitioner or other member of that single specialty group practice provides the health care services to a patient pursuant to a referral or in accordance with a consultation requested by another health care practitioner who does not have a beneficial interest in the health care entity; or (ii) the health care practitioner or other member of that single specialty group practice referring a patient to the facility, service, or entity personally performs or supervises the health care service or procedure.”
- A health care practitioner with a beneficial interest in, or compensation arrangement with, a hospital or related institution, facility, service, or other entity owned or controlled by a hospital or related institution (or under common ownership or control) if the beneficial interest or compensation
arrangement was in effect on January 1, 1993, and it has not increased since then.

- Treatment of an enrollee in a provider-sponsored organization when enrollees are referred to an affiliated health care provider of the provider-sponsored organization.
- Referrals of end-stage renal disease patients to a dialysis facility.
- "Whole hospital" ownership interests where the physician-owner is authorized to provide services at the hospital.
- A health care practitioner who has a compensation arrangement with a health care entity, if the compensation arrangement is funded by certain federally-authorized accountable care organization (ACO) models or CMS-approved alternative payment models.*

Requires a health care practitioner with a beneficial interest in a health care entity, prior to making a referral to the entity utilizing certain of the statutory exemptions to: disclose the existence of the beneficial interest to each referred patient in writing, inform the patient of his/her right to obtain the health care service from another health care entity, require the patient to acknowledge receipt of the statement in writing, document the written acknowledgement in the patient’s medical record along with the valid medical need for the referral, and permanently display a plainly visible written notice of the beneficial interest in the practitioner's office.

Requires a health care practitioner to disclose the name of the referring health care practitioner on each request for payment or bill submitted to a third-party payor that may be responsible for payment in whole or in part, if the health care practitioner knows or has reason to believe that there’s been a referral by a health care practitioner and the referring health care practitioner has a beneficial interest in or compensation arrangement with health care entity that is prohibited under the Maryland Self-Referral Law.

Establishes restrictions on purchasing, marking up, and billing payors for anatomical pathology services. Such services must be performed: (1) by the billing health care practitioner who directly or indirectly charges, bills, or otherwise solicits payment for the anatomical pathology services; or (2) under the direct supervision of the billing health care practitioner; and (3) in accordance with "the provisions for the preparation of biological products by service in the federal Public Health Service Act." If the physician or medical group obtains certification for its anatomical pathology laboratory under the Clinical Laboratory Improvement Amendments of 1988 section of the Public Health Service Act, it appears this third criterion will be satisfied. A patient, third-party payor, hospital, public health clinic, or nonprofit health clinic is not required to reimburse a health care practitioner for these restricted services. Exceptions from the statutory restrictions exist for a referring laboratory that must send specimens to another clinical laboratory for histologic processing or anatomical pathology consultations, and for a health care practitioner who takes a Pap test specimen from a patient and orders, but does not supervise or perform an anatomical pathology service on the specimen. (This amendment to the
Maryland Self-Referral Law was passed in 2008 by the Maryland General Assembly to prevent physicians or medical groups who perform no portion of an anatomical pathology service from purchasing the service from a pathology group or lab, marking up the price, and billing the patient or third-party payors the marked-up rate.)

A health care practitioner who fails to comply with any provisions of the statute is subject to disciplinary action and investigation by the appropriate regulatory board. The health care entity, referring practitioner, or other person furnishing a health care service pursuant to a prohibited referral is jointly and severally liable to the payor for any reimbursement received for the service, if the health care entity, referring practitioner, or other person knew or should have known of the violation. The referring health care practitioner, health care entity, or other person furnishing the services denied as a prohibited referral, may not submit a claim, bill, or other demand or request for payment to the recipient of the health care services. (Payor remedies also are covered under Maryland Health Insurance Article § 15-110 and Maryland Health-General Article § 19-712.4, discussed below.)

* The Maryland Self-Referral Law was enacted in 1993 when fee-for-service was the predominant method of payment. Maryland has an all-payor model contract with the federal Center for Medicare and Medicaid Innovation (CMMI); the Maryland Health Services Cost Review Commission advised that shared savings arrangements between hospitals and physicians, approved by CMMI, could violate the Maryland Self-Referral Law. The Maryland legislature modified the Maryland Self-Referral Law in order to protect and encourage current and future CMS-approved payment models, including: value-based payment models, risk-sharing arrangements, alignment models, and other emerging compensation arrangements.

**COMAR 10.01.15 (Maryland Self-Referral Law Regulations)**

Describes the procedure whereby a health care practitioner who has or wishes to have a beneficial interest in a health care entity may request an exemption and renewal of exemption from the statutory self-referral prohibition from the Secretary of the Maryland Department of Health. Requires the requesting health care practitioner to show that the health care practitioner's beneficial interest is:

(1) “Essential to finance and to provide the health care entity;” and
(2) “Needed to ensure appropriate access for the community to the services provided at the health care entity.”

Requires the requesting health care practitioner to include an agreement that if a renewal of the exemption is submitted and the Secretary no longer deems the beneficial interest to be essential, the health care practitioner will pledge in writing to immediately cease accepting referrals prohibited under Maryland’s Self-Referral Law or divest the health care practitioner’s beneficial interest in the entity within one (1) year after the exemption is no longer applicable.
Requires the Secretary to request, in writing, the advice of the Executive Director of the Maryland Health Care Commission (MHCC) concerning whether the beneficial interest is needed to ensure appropriate access for the community to the services provided by the health care entity, and for the Executive Director of the MHCC to advise the Secretary accordingly.

Interprets the following definitions and terms: “area of concentration,” “essential,” “group practice” (incorporating portions of the federal Stark Law definition), “health care entity,” “health care practitioner,” “health care service,” “members of the group,” “MHCC,” “patient care services,” “personally supervised,” “rental or lease of office space” (to include rental of equipment and staff), “referring health care practitioner,” “Secretary,” and “specialty.”

**Maryland Insurance Article, § 15-110**

Incorporates the definitions of “health care practitioner,” “health care service,” and “prohibited referral” from the Maryland Self-Referral Law §§ 1-301 and 1-302.

Permits insurers and nonprofit health service plans that issue or deliver individual or group health insurance policies in the State of Maryland to seek: (1) repayment from a health care practitioner of any moneys paid for a claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral; and (2) a refund of a payment made for a claim, bill, or other demand or request for payment that is subsequently determined to be for a health care service provided as a result of a prohibited referral.

Requires each individual and group health insurance policy that is issued for delivery in Maryland by an insurer or nonprofit health service plan and that provides coverage for health care services to include a provision that excludes payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

Requires insurers and nonprofit health service plans that issue or deliver individual or group health insurance policies in the State of Maryland to report to the Commissioner and the appropriate regulatory board any pattern of claims, bills, or other demands or requests for payment submitted for health care services provided as a result of a prohibited referral within 30 days after the entity has knowledge of the pattern.

Does not require insurers and nonprofit health service plans to audit or investigate a claim, bill, or other demand or request for payment for health care services to determine whether those services were provided as a result of a prohibited referral; however, if an insurer or plan does conduct an audit or investigation to determine whether those services were provided as a result of a prohibited referral, such audit or investigation is not grounds to delay payment.
Maryland Health-General Article, § 19-712.4
Incorporates the definitions of “health care practitioner,” “health care entity,” and “health care service” from the Maryland Self-Referral Law § 1-301.

Permits HMOs to seek: (1) repayment from a health care practitioner of any money paid for a claim, bill, or other demand or request for payment for health care services that the appropriate regulatory licensing board determines were provided as a result of a prohibited referral; and (2) a refund of a payment made for a claim, bill, or request for payment that is subsequently determined to be for a health care service provided as a result of a prohibited referral.

Requires each HMO individual and group subscriber agreement to include a provision that excludes payment of any claim, bill, or other demand or request for payment for health care services determined to be a prohibited referral.

Requires HMOs to report to the commissioner and the appropriate regulatory board any pattern of claims, bills, or other demands or requests for payment submitted for a health care service provided as a result of a prohibited referral within 30 days after the entity has knowledge of the pattern.

Does not require an HMO to audit or investigate any claim, bill, or other demand or request for payment to determine whether the health care services were the result of a prohibited referral; however, if an HMO does conduct an audit or investigation to determine whether those services were the result of a prohibited referral, such audit or investigation is not grounds to delay payment or waive its statutory prompt payment of claims obligations.

The term “referral” as used in the Maryland Self-Referral Law includes: (1) a pediatrician’s recommendation that parents obtain a presently needed medical service for their child at an off-hours facility separate from the pediatrician’s daytime medical practice; and (2) a pediatrician’s presentation of information about the off-hours facility in such a manner as to encourage parents to use the services of the facility when the need for acute care during off-hours arises in the future. The term “referral” does not include a pediatrician’s provision of neutral information about the off-hours facility, along with comparable information about other sources of off-hours acute care. [The statutory language defining “referral” at Maryland Health Occupations Article § 1-301(l) reads as follows: “(1) ‘Referral’ means any referral of a patient for health care services. (2) ‘Referral’ includes: (i) The forwarding of a patient by one health care practitioner to another health care practitioner or to a health care entity outside the health care practitioner's office or group practice; or (ii) The request or establishment by a health care practitioner of a plan of care for the provision of health care services outside the health care practitioner's office or group practice.”]
The term “health care services” embraces a future series of diagnostic or treatment services so that if a patient has a condition that will likely call for recurrent medical services of some kind, and if a practitioner describes the availability of such services at a facility outside the practitioner’s office or group practice, as a practical matter the pediatrician-investor will have established a “plan of care” for those anticipated, specific services.

Whether a health care practitioner has made a referral by requesting or establishing a plan of care for the provision of health care services outside the practitioner’s office or group practice depends on the extent to which the practitioner steers the patient (or the patient’s parents, in the case of a pediatric patient) to the outside facility.

83 Opinions of the Attorney General 142 (1998)
Because of the absence of an isolated transaction or similar applicable compensation arrangement exemption in the Maryland Self-Referral Law, the purchase by a hospital affiliate of a professional medical corporation owned by primary care physicians would render all referrals by the primary care physicians to the hospital illegal under the Maryland Self-Referral Law (assuming the relationship between the hospital and its affiliate was such that a compensation arrangement with the affiliate would be treated as a compensation arrangement with the hospital).
[Note: this decision pre-dates the amendment of the Maryland Self-Referral Law to include an express exemption for the sale of a health care practice.]

A compensation arrangement that is between a managed care company and independent contractor specialist physicians who refer patients to physician-employees of the managed care company, and that is for practice billing and administrative services provided by the managed care company to the referring physicians in return for a percentage of the professional fees collected by the managed care company on behalf of those physicians, satisfies the following requirements of the Maryland Self-Referral Law’s independent contractor exemption: that the arrangement be for identifiable services and that the amount of the compensation be determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the physicians. No determination can be made on the facts as to whether it is consistent with fair market value or is commercially reasonable even in the absence of referrals. The same analysis would apply where the independent contractor specialist physician also serves as medical director of a physician-hospital organization (PHO) and controls all referrals by the PHO to participating and non-participating physicians, and therefore can direct patients to the specialty care physicians who have agreements with the managed care company. [Note: it is unclear from this opinion whether the Attorney General views the Maryland Self-Referral Law’s independent contractor arrangement exception as applying only to situations where the practitioner is the contractor receiving the compensation, and therefore believes this exception applies to the above-described compensation arrangement because the services provided by the managed care company constitute remuneration creating the compensation

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arrangement. The express language of the statutory exception does not appear to preclude its application to a situation in which the referring practitioner is the payor of the compensation and recipient of the services.]

The Maryland Self-Referral Law’s exemption [§ 1-302(d)(1)] for referrals by a physician when treating a member of a HMO, if the physician does not have a beneficial interest in the entity to which the referral is made, would also permit referrals of HMO patients by the specialist physicians to the managed care company’s employed physicians as described above because the referring specialist physicians do not have a beneficial interest in the managed care company. [The AG’s reasoning in reaching this conclusion is not clear.]

The term “referral” under the Maryland Self-Referral Law encompasses in-office as well as out-of-office referrals.

The Maryland Self-Referral Law bars a physician in any non-radiology medical practice from referring patients for tests on an MRI machine or CT scanner owned by that practice, regardless of whether the services are performed by a radiologist employee or member of the practice or by an independent radiology group. Neither the in-office ancillary services exemption [§ 1-302(d)(4)] nor the exemption for referrals within a group practice [§ 1-302(d)(2)] is applicable to such an arrangement so as to permit such referrals.

91 Opinions of the Attorney General 49 (2006)
The Maryland Self-Referral Law bars a physician in any non-radiology medical practice from referring patients for tests on an MRI machine or CT scanner owned or leased by that practice, even if all of the scans were performed by or under the direct supervision of the referring practitioner. The Maryland Self-Referral Law exemption for referrals of a patient to a health care entity for health care services or tests, if the services or tests are personally performed by or under the direct supervision of the referring health care practitioner [§ 1-302(d)(3)], is not applicable to such an arrangement so as to permit such referrals. This exemption was intended to create an exemption for referrals of a patient for services or tests to a health care entity that is outside of the referring practitioner’s practice, not for referrals within the same entity or practice.

The term “health care service” as used in the Maryland Self-Referral Law includes, but is not limited to, the ordinary medical activities performed by a physician in the course of treatment for the specific specialty (e.g., setting a broken arm for an orthopedist; performing an electrocardiogram for a cardiologist, etc.).

Attorney General Advice Letter to Delegate Peter A. Hammen, December 9, 2005
Interprets the Maryland Self-Referral Law group practice exception [Maryland Health Occupations Article, § 1-302(d)(2)], direct supervision exception [Maryland Health
Scenario 1: A urology group sets up a small histology laboratory in its office and contracts with an independent pathology group to staff the laboratory and produce histology slides (technical component of a pathologic examination), and provide a pathologic diagnosis (professional component) on the prepared slides. The urology group bills the patient for the technical component, which is performed in its laboratory, and the pathology group bills the patient for the professional component, whether performed in the laboratory or elsewhere. This scenario assumes a urologist has the expertise to determine whether a biopsy should be done and how many samples should be taken and to perform the procedure, but does not have the expertise to perform a pathologic examination.

The group practice exception does not apply because the pathologists are not members of the urology group practice; they are members of their own independent group practice and a substantial portion of their professional services (the professional component of the histology lab services) are billed separately from the urology group practice.

The direct supervision exception does not apply because: (1) neither the technical nor the professional component of the examination is being performed by the referring practitioner; and (2) since the urologists do not have the expertise to perform pathology examinations, they could not provide the necessary supervision of those examinations to fall within the direct supervision exception. To satisfy the “direct supervision” requirement, the supervising physician not only must be present on the premises where the services are being performed, but also must be personally qualified to perform such services.

The in-office ancillary services exception does not apply because: (1) it is not clear that pathology examinations are “basic services” or are “routinely provided” in the offices of physicians, and therefore may not qualify as “in-office ancillary services;” (2) they do not meet the “furnishing” requirement of the exception because they are not being personally furnished by the referring practitioner, or by a practitioner in the same group practice as the referring practitioner (the pathologists are not members of the urology group practice), or by an individual who is employed and personally supervised by the referring health care practitioner or a practitioner in the same group practice as the referring practitioner (the contracting pathologists are not employees of the urology practice and the urologists are not qualified to supervise the pathology examinations).

Scenario 2: The urology group submits the specimen to an independent commercial laboratory to perform the technical component of the pathology examination, and the commercial laboratory bills the patient directly. The prepared slides are then sent to
the urology group, which contracts with a pathologist to perform the professional component on the prepared slides for a set fee. The group pays the pathologist and bills the patient for the service. The urology group might contract with the pathologist for a fee that is below the standard diagnostic rate and bill the patient at the standard rate.

The below market rate charged by the pathologist to the urology group takes this arrangement out of the independent contractor arrangement exception because the compensation is not at fair market value and the acceptance of such a discount by the pathologist presumably reflects the value and volume of the referrals.

For the same reasons discussed under Scenario 1 above, the group practice, direct supervision, and in-office ancillary services exceptions also do not apply to this scenario.

[Attorney General advice letters are not maintained on the Attorney General’s public website; please see Attachment #1 at the end of this document for the full text of this letter.]

Maryland Board of Physicians Declaratory Ruling 2006-1, December 20, 2006
[This ruling was upheld by the State Circuit Court in Montgomery County and by the Maryland Court of Appeals—see discussion below.]
Interprets the meaning of three exemptions to the Maryland Self-Referral Law as applied to a referral by an orthopedic physician for an MRI to be performed on or by an MRI machine owned or leased by the orthopedic practice of which the physician is an owner.

(1) The exemption for a referral of a patient by a health care practitioner to another health care practitioner in the same group practice [Maryland Health Occupations Article, § 1-302(d)(2)] was intended to create an exception where the referral transfers a patient, permanently or temporarily, from one health care practitioner in a group practice to another, not where the referring practitioner continues treating the patient as his or her own patient and simply orders specific "tests" or "services" from another member of the group. Consequently, this exemption does not apply to the above-described referral.

(2) The second exemption exempts a referral of a patient by a health care practitioner with an ownership interest in a health care entity to that entity for health care services or tests personally performed by or under the direct supervision of the referring health care practitioner [Maryland Health Occupations Article, § 1-302(d)(3)]. This exemption was intended to create an exemption for referrals of a patient for services or tests to a health care entity that is outside of the referring practitioner’s practice, even if the referring practitioner holds an ownership interest in the outside entity, so long as the referring practitioner is personally present within the treatment area when the service is performed and either personally providing the service or directly supervising that service. The term "health care entity" in this
exemption does not include the referring practitioner’s own group practice, and therefore this exemption does not apply to the above-described referral.

(3) The above-described referral is not exempted from the Maryland Self-Referral Law’s prohibition under the in-office ancillary services exemption [Maryland Health Occupations Article, § 1-302(d)(4)] because MRI services are expressly carved out of that exemption under the law.

The above-described referral would still violate the Maryland Self-Referral Law even if the referring physician obtains a signed Maryland Uniform Consultation Referral Form from the patient’s primary care physician after the physician determined the MRI was necessary, but before the MRI was actually conducted, if the primary care physician does not, between the time the referring physician determines the MRI is necessary and the time the MRI was accomplished, see the patient for the purpose of determining if the MRI is necessary, and does not exercise independent medical judgment as to whether the MRI is appropriate or necessary.

The above-described referral would still violate the Maryland Self-Referral Law even if the referring physician names the primary care physician as the "referring physician" in the Health Insurance Claim Form.

The Maryland Board of Physicians will not take any disciplinary action against any physician for self-referrals ruled illegal under this Declaratory Ruling based on any referrals made prior to the date of the Ruling.

*For further guidance on the Maryland Board of Physicians’ interpretation of Declaratory Ruling 2006-1 and §§ 1-302(a) and 1-302(c) of the Maryland Self-Referral Law, see the Maryland Board of Physicians’ Consent Agreement attached as Attachment #2 at the end of this summary).

**Maryland Board of Physicians Declaratory Ruling 2006-2, December 29, 2006**

Interprets the meaning of several different exemptions to the Maryland Self-Referral Law as applied to two different factual scenarios involving a histology laboratory owned by a urology group:

(1) A urology group sets up a small histology laboratory within its office and contracts with an independent pathology group to staff the laboratory and perform the professional and technical components of the pathology services. Members of the urology group refer patients (or specimens from patients) to the laboratory. The urology group then pays the pathology group a set fee for each slide prepared and bills the patient for the technical component. The pathology group bills separately for the professional component. The group practice exemption [Maryland Health Occupations Article, § 1-302(d)(2)] does not apply because the contracted pathology group is independent and not a member of the same group practice as the referring urologists. The direct supervision exemption [Maryland Health Occupations Article, § 1-302(d)(3)] does not apply because neither the referring urologist, nor a practitioner
within his or her group practice, is performing or supervising the preparation of the histology slides (the performance and supervision are being performed by the outside pathology group) and because the referral for the pathology services is not to an entity outside of the referring urologist’s office or group practice, but to a laboratory located within the referring urologist’s office and group practice. “Direct supervision” for purposes of this exemption requires supervision, not merely physical presence on the premises.

(2) A urology group submits a biopsy specimen to an independent commercial laboratory that prepares the slides and bills the patient directly for the technical component of the pathology examination. The prepared slides are then sent to the urology group’s office. The urology group contracts with a pathologist to perform the professional component, pays the contracted pathologist a set fee per slide that is below the market rate for this professional component, and then bills the patient at the market rate for the professional component. This compensation arrangement does not fit within the Maryland Self-Referral Law’s independent contractor exception [Maryland Health Occupations Article, § 1-301(c)(2)(iii)] because the compensation is not at fair market value. It also does not fit within the in-office ancillary services exception [Maryland Health Occupations Article, § 1-302(d)(4)] because the pathology examinations are not being personally furnished by or personally supervised by the referring practitioner or a member of the referring practitioner’s group. The pathology examinations are being performed by the outside pathologists, who are not members of the referring practitioner’s group practice.

In Board Case No. 2006-1, Case No. 277833-V, Circuit Court for Montgomery County, Maryland (October 18, 2007)
[This decision was appealed by petitioner to the Maryland Court of Appeals, which affirmed the decision. See discussion below.]

The Petitioner, a coalition of non-radiology physician practices, each of which provides MRI services directly to its patients, asked the court to review and overturn the Maryland Board of Physicians Declaratory Ruling 2006-1 interpreting the meaning of three exemptions to the Maryland Self-Referral Law as applied to a referral by an orthopedic physician for an MRI to be performed on or by an MRI machine owned or leased by the orthopedic practice of which the physician is an owner.

The court upheld the Maryland Board of Physicians’ interpretation of all three exemptions, ruling as follows:

- The “ancillary services exception” [Maryland Health Occupations Article, § 1-302(d)(4)], does not permit orthopedist referrals for MRI or CT scans because the definition of “ancillary services” specifically excludes MRI and CT scans for all doctors except radiologists.

- While the “group practice exception” [Maryland Health Occupations Article, § 1-302(d)(2)] is plain on its face and on its face permits orthopedists to refer patients for MRI or CT scans within the same group practice, such an
interpretation is inconsistent with and would render meaningless the "ancillary services exception." Reading the statute as a whole, the court concurred with the Board's ruling that the "group practice exception" is limited to referrals that transfer the professional responsibility of a patient's continued care from one health care practitioner to another in the same group practice.

- While the "direct supervision exception" [Maryland Health Occupations Article, § 1-302(d)(3)] is plain on its face and on its face permits an orthopedist to refer patients for MRI or CT scans within the same group practice if the referring orthopedist directly supervises the scans, such an interpretation is inconsistent with and would render meaningless both the "ancillary services exception" and the "group practice exception." Reading the statute as a whole, the court concurred with the Board's ruling that the "direct supervision exception" is limited to referrals outside the group practice when the referring doctor is physically present.

[This is an unpublished opinion; please see Attachment #3 at the end of this document for the full text of this opinion.]


The appellant, a coalition of non-radiology physician practices, each of which provides MRI services directly to its patients, asked Maryland's highest court to overturn a lower court ruling upholding the Maryland Board of Physicians Declaratory Ruling 2006-1 interpreting the meaning of the Maryland Self-Referral Law as applied to a referral by an orthopedic physician for an MRI to be performed on or by an MRI machine owned or leased by the orthopedic practice of which the physician is an owner.

The court upheld the lower court ruling and the Maryland Board of Physicians interpretation of all three exemptions, ruling as follows:

- The Maryland Board of Physicians Declaratory Ruling 2006-1 was not premised upon an erroneous conclusion of law, and the judgment of the circuit court is affirmed.
- The Maryland Board of Physicians was correct in ruling that:
  - The "group practice exception" [Maryland Health Occupations Article, § 1-302(d)(2)] does not permit an orthopedic surgeon to refer his or her patient for an MRI or CT scan to be performed by another member of the orthopedic surgeon's practice group.
  - The "direct supervision exception" [Maryland Health Occupations Article, § 1-302(d)(3)], which is limited to referrals to "outside" entities, requires the referring physician be personally present within the treatment area when the service is performed and either personally providing the service or directly supervising that service.

*This is an unreported opinion and it cannot serve as either precedent within the rule of stare decisis or as persuasive authority. (Maryland Rules, Rule 1-104)

Following the receipt of complaints regarding an individual physician and his affiliated practice potentially violating the Maryland Self-Referral Law, the Maryland Board of Physicians (“MBOP”) entered into a consent agreement with the physician, resolving the matter. Appellants (three third-party health care providers) sued the MBOP seeking an administrative mandamus to compel the MBOP to issue a declaratory ruling regarding its interpretation of the Maryland Self-Referral Law in the consent agreement and a declaratory judgment for similar reasons. The Circuit Court granted the MBOP’s motions to dismiss due to the appellants’ lack of standing, and it was appealed to the Court of Appeals.

Appellants argued that they were entitled to an administrative writ of mandamus to compel the MBOP to issue a declaratory ruling so that they would have an unambiguous interpretation of the Maryland Self-Referral Law. The MBOP contended that its decision whether or not to issue a declaratory ruling was completely discretionary. The Court of Appeals held that the appellants did not have a substantial right that was prejudiced by the MBOP’s decision to not issue a declaratory ruling and the administrative writ of mandamus they sought was properly dismissed.

The Court of Appeals also upheld the dismissal of appellant’s motion for declaratory judgment because the appellants were not asserting that the MBOP had failed to issue a declaratory ruling to any of them individually, rather they wanted to prevent future hypothetical or abstract consequences and did not have a current dispute with the MBOP that could be resolved with a declaratory judgment.

Lastly, the Court of Appeals found that there is no private right of action under the Maryland Self-Referral Law because it is a general prohibition that doesn’t bestow a right upon any class or person and that the overall purpose of the Maryland Self-Referral Law in the context of the Health Occupations Article was to provide rules and procedures for the regulation of various boards.

3) FALSE CLAIMS/FRAUD & ABUSE

Maryland Health-General Article §§ 2-501, 2-502, 2-503, 2-504, 2-405.1, 2-505 (Health Program Integrity and Recovery Activities)

Defines “abuse,” “claim,” “employee,” “fraud,” “program,” “provider,” “recipient,” and “recovery.”

Authorizes such Office to investigate fraud, waste, and abuse of departmental funds.

Requires such Office to cooperate with and coordinate investigative efforts with the Medicaid Fraud Control Unit, and where warranted, refer the matter to the Medicaid Fraud Control Unit. Requires such Office to cooperate with and coordinate investigative efforts with departmental programs and other State and federal agencies to ensure a provider isn’t subject to duplicative audits.

Grants such Office subpoena authority for the purpose of investigating fraud, waste, or abuse of departmental funds; including petitioning a court to compel compliance with such a subpoena.

Authorizes such Office, in collaboration with the appropriate departmental program, to recover any mistaken claims paid, payments obtained in error, or fraudulent claims paid to or obtained by a provider; and to recover the cost of benefits mistakenly paid or obtained in error, or fraudulently paid to or obtained by a recipient.

Authorizes such Office with the sole discretion to impose a civil money remedy against a provider for a violation of State or federal law governing the conditions of payment for any service or item for which the provider submitted a claim for payment and received payment. Such civil money remedy is in lieu of the provider’s full payment or full adjustment of the paid claim (not in addition to repayment of the claim); may not be less than the federal financial participation share of the identified improper claim amount; may not be imposed if the claim was included in the universe of claims under an extrapolation calculation; and is only available if the provider hasn’t been subjected to a repayment penalty or fine, criminal action, or civil false claims action under federal or State law for the same claim. The civil money remedy cannot exceed the amount that the provider was reimbursed for the paid claim. Factors considered when deciding whether to impose a civil remedy and in setting the amount: the number, nature, and seriousness of the violations; the provider’s history of compliance; the provider’s efforts to correct the violations and whether the provider continued the conduct after being notified of possible violations; the provider’s cooperation with the review of the claim; the degree of risk to the health, life, or safety of consumers as a result of the violations; and any other reasonable factors, including giving special consideration to the extent that the provider’s size, operations, or financial condition may have contributed to the violations and may affect the provider’s ability to provide care and continue operations after paying the civil money remedy. Any civil money remedy must be imposed by detailed written order and is subject to the provider’s right to contest the order under the Maryland Administrative Procedure Act.

Provides immunity from civil liability for any person making a report in good faith of fraud, waste, or abuse, or participating in any investigation related to fraud, waste, or abuse.
Protects employees from retaliatory actions by employers when the employee discloses (or threatens to disclose) to a supervisor or to a public body a suspected violation, provides information to or testifies before, a public body conducting an investigation, hearing, or inquiry into a suspected violation, or objects to or refuses to participate in a suspected violation of the statute by an employer. Requires employers to display notice of and inform employees of these protections. Provides employees with a right to civil action if the employer does engage in retaliatory actions, and grants a court the authority to issue an injunction, reinstate the employee, remove any adverse personnel records, reinstate full fringe benefits and seniority rights, require compensation for lost wages and benefits, and assess reasonable attorneys’ fees. Does not apply to “employees” covered under the Health Care Whistleblower Protection Act or State employees.

**Maryland Health-General Article §§ 2-601, 2-602, 2-603, 2-604, 2-605, 2-606, 2-607, 2-608, 2-609, 2-610, 2-611 (False Claims Against State Health Plans and State Health Programs)**

Establishes a State civil false claims act. Defines “claim,” “documentary material,” “employee,” “employer,” “knowing or knowingly,” “material,” “obligation,” “provider,” “public body,” “retaliatory action,” “State health plan,” “State health program,” and “supervisor.”

**Definition of Claim**
"Claim" is defined as a request or demand, under a contract or otherwise, for money or other property, whether or not the State has title to the money or property, that is:

1. Presented through a State health plan or a State health program to an officer, employee, or agent of the State; or
2. Made to a contractor, grantee, or other recipient, if the money or other property is to be spent or used on the State’s behalf or to advance a State interest through a State health plan program, and the State: (a) provides or has provided any portion of the money or other property requested or demanded; or (b) will reimburse the contractor, grantee, or other recipient for any portion of the money or other property that is requested or demanded.

**Prohibitions**
Prohibits a person from doing any of the following:

1. Knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval;
2. Knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit a violation of the false or fraudulent claim prohibition;
4. Having possession, custody, or control of money or other property used by or on behalf of the State under a State health plan or program and knowingly...
delivering or causing to be delivered to the State less than all of that money or other property;

(5) (a) Being authorized to make or deliver a receipt or other document certifying receipt of money or other property used or to be used by the State under a State health plan or program; and (b) intending to defraud the State or the Department of Health by making or delivering a receipt or document knowing that the information contained in the receipt or document is not true;

(6) Knowingly buying or receiving as a pledge of an obligation or debt publicly owned property from an officer, employee, or agent of a State health plan or program who lawfully may not sell or pledge the property;

(7) Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or other property to the State;

(8) Knowingly concealing, or knowingly and improperly avoiding or decreasing, an obligation to pay or transmit money or other property to the State; or

(9) Knowingly making any other false or fraudulent claim against a State health plan or program.

Civil Penalties
Provides for civil penalties of $10,000 per violation plus treble damages. Total civil penalty owed for a violation may not be less than amount of the actual damages to the State health plan or program as a result of the violation. These penalties are in addition to any criminal, civil, or administrative penalties provided under any State or federal statute or regulation.

Criteria for Assessing Penalties
Establishes criteria for determining severity of the civil penalties to be assessed, including: number, nature, and severity of violations; history of previous violations; degree of loss suffered by the State health plan or program; history of billing compliance; whether the violator has a compliance plan in place; corrective action already taken; extent of harm or detriment to patients; any funds previously returned to the State health plan or program by the violator in compliance with federal requirements regarding overpayments; and whether the violator self-reported, timeliness of self-reporting, cooperated in the investigation, and if the violator had prior knowledge of the investigation. Requires the following be considered in weighing the above factors: size, operations, and financial condition of the violator as it may have affected these factors, and the extent to which such size, operations, and financial condition may affect the violator’s ability to provide care and continue operations after payment of damages and fines.

Civil Action by the State
The State is authorized to file a civil action against a violator to seek the civil penalties detailed above, along with court costs and attorneys’ fees.
**Whistleblower Action and Protections**

Provides for qui tam action and award of between 15–25% of proceeds of action or settlement (proportional to the time and effort of the whistleblower) if the State intervenes, along with reimbursement of expenses and attorneys’ fees. Reduces proceeds for whistleblowers later found to have planned, initiated, or otherwise deliberately participated in the action that the qui tam case is based upon. Dismisses from the qui tam case and requires repayment of proceeds awarded to a whistleblower later convicted of criminal conduct in connection with the violation that the qui tam case is based upon. Creates statute of limitations of later of six years after occurrence of violation, or three years after date when facts material to the right of action are known (or reasonably should have been known) by the relator, the State Inspector General, or the Director of the State Medicaid Fraud Control Unit, but in no event more than ten years after the date of the violation. Prohibits retaliation against whistleblowers and provides whistleblowers with a right to file civil action against employers who retaliate, and requires employers to display notices of such protections and employer obligations, and to use any other appropriate means of informing employees of such protections and obligations. Provides various civil remedies for employees who have been retaliated against by their employers. Restricts qui tam actions by current or former State employees who had an existing duty to report or investigate such wrongdoing, actions based on allegations in which the State is already named as a party, actions based on public disclosure of allegations, and actions by State employed auditors, investigators, attorneys, financial officers, or contracting offices regarding information learned while working in that capacity. Provides for the award of attorneys’ fees and court costs to a defendant if the defendant prevails in the qui tam case and the court finds that the whistleblower initiated the case primarily to harass the defendant or otherwise in bad faith. This statute does not apply to State employee or an employee defined under the Health Occupations statute (who may file such a claim under the Health Care Whistleblower Protection Act).

**Annual Reports to General Assembly**

Requires annual reports to the General Assembly regarding civil actions filed under the statute.

**Maryland Criminal Law Article §§ 8-508, 8-510, 8-511, 8-512, 8-513, 8-514, 8-515, 8-516, 8-517 (Medicaid Fraud)**

Defines “false representation,” “health care services,” “representation,” “serious injury,” and “State health plan.” Applies to the Maryland Medicaid program; insurers, health maintenance organizations (HMOs), managed care organizations (MCOs), health care cooperatives or alliances, or any other person that contracts with the Medicaid program to provide health care services reimbursable by the Medicaid program; and their subcontractors (each a “State health plan”).

Prohibits a person from: (1) knowingly and willfully defrauding or attempting to defraud a State health plan in connection with the delivery of or payment for a health care service; (2) knowingly and willfully obtaining or attempting to obtain by means
of a false representation money, property, or any thing of value in connection with the delivery of or payment for a health care service that wholly or partly is reimbursed by or is a required benefit of a State health plan; (3) knowingly and willfully defrauding or attempting to defraud a State health plan of the right to honest services; or (4) with the intent to defraud making a false representation relating to a health care service or a State health plan.

Prohibits a person who has applied for or received a benefit or payment under a State health plan for the use of another individual from knowingly and willfully converting all or any part of a State health plan benefit or payment to a use that is not for the authorized beneficiary.

Prohibits a person who provides to another individual items or services for which payment wholly or partly is or may be made from federal or State funds under a State health plan, from soliciting, offering, making, or receiving a kickback or bribe in connection with providing those items or services or with making or receiving a benefit or payment under a State health plan.

Prohibits a person from soliciting, offering, making, or receiving a rebate of a fee or charge for referring another individual to a third person to provide items or services for which payment wholly or partly is or may be made from federal or State funds under a State health plan.

Prohibits a person from knowingly and willfully making, causing to be made, inducing, or attempting to induce the making of a false representation with respect to the conditions or operation of a facility, institution, or State health plan in order to help the facility, institution, or State health plan qualify to receive reimbursement under a State health plan.

Prohibits a person from knowingly and willfully obtaining, attempting to obtain, or aiding another individual in obtaining or attempting to obtain a drug product or medical care, the payment of all or a part of which is or may be made from federal or State funds under a State health plan, by: (1) fraud, deceit, false representation, or concealment; (2) counterfeiting or alteration of a medical assistance prescription or a pharmacy assistance prescription distributed under a State health plan; (3) concealment of a material fact; or (4) using a false name or a false address.

Prohibits a person from knowingly and willfully possessing a medical assistance card or a pharmacy assistance card distributed under a State health plan or the Maryland Medical Assistance or Pharmacy Assistance Program without the authorization of the person to whom the card is issued.

Provides for the following criminal penalties:

(1) A violation resulting in the death of an individual constitutes a felony subjecting a convicted offender to imprisonment not exceeding life, or a fine not exceeding $200,000, or both;
(2) A violation resulting in serious injury to an individual constitutes a felony subjecting a convicted offender to imprisonment not exceeding 20 years, or a fine not exceeding $100,000, or both;

(3) A violation involving money, health care services, or other goods or services worth $1,500 or more in the aggregate constitutes a felony subjecting a convicted offender to imprisonment not exceeding five years, or a fine not exceeding $100,000, or both;

(4) Any other violation constitutes a misdemeanor subjecting a convicted offender to imprisonment not exceeding three years; or a fine not exceeding $50,000; or both; and

(5) An association, firm, institution, partnership, or corporation violating this statute is subject to a fine not exceeding $250,000 for each felony and $100,000 for each misdemeanor.

Provides for civil penalties in an amount not more than three times the amount of the overpayment, in addition to any other penalty provided by law and any right the victim may have to restitution under the Maryland Criminal Procedure Article.

4) GENERAL WHISTLEBLOWER PROTECTIONS

Maryland Health Occupations Article §§ 1-501, 1-502, 1-503, 1-504, 1-505, 1-506 (Health Care Worker Whistleblower Protection Act)

Defines “Board,” “employee,” and “supervisor.”

Prohibits an employer from taking or refusing to take any personnel action as reprisal against an employee because the employee discloses or threatens to disclose to a supervisor or board an activity, policy, or practice of the employer that is in violation of a law, rule, or regulation; provides information to or testifies before any public body conducting an investigation, hearing, or inquiry into any violation of a law, rule, or regulation by the employer; or objects to or refuses to participate in any activity, policy, or practice in violation of a law, rule, or regulation.

This whistleblower protection applies only if:

(1) The employee has a reasonable, good-faith belief that the employer has, or still is, engaged in an activity, policy, or practice that is in violation of a law, rule, or regulation;

(2) The employer's activity, policy, or practice that is the subject of the employee's disclosure poses a substantial and specific danger to the public health or safety; and

(3) Before reporting to the board:

(a) The employee has reported the activity, policy, or practice to a supervisor or administrator of the employer in writing and afforded the employer a reasonable opportunity to correct the activity, policy, or practice; or
(b) If the employer has a corporate compliance plan specifying who to notify of an alleged violation of a rule, law, or regulation, the employee has followed the plan.

The whistleblower may institute a civil action against the offending employer in the county where the violation occurred, in the employee’s county of residence, or in the county where the employer maintains its principal offices in Maryland. The action must be brought within one year after the alleged violation, or within one year after the employee first became aware of the alleged violation. Remedies available to the employee include an injunction to restrain continued violations; reinstatement of the employee to the same, or an equivalent position held before the violation; removal of any adverse personnel record entries based on or related to the violation; reinstatement of full fringe benefits and seniority rights; compensation for lost wages, benefits, and other remuneration; and reasonable attorneys’ fees and other litigation expenses. If the court determines that the action was brought by the employee in bad faith and without basis in law or fact, the employer may recover its attorneys’ fees and expenses. In any action brought under this statute, it is a defense that the personnel action was based on grounds other than the employee’s exercise of any rights protected under the statute.

**Maryland Health-General Article § 2-505**
Extends to employees who are not State employees or licensed health care practitioners, similar whistleblower protections to those found in the Health Care Worker Whistleblower Protection Act (discussed above). See discussion in False Claims/Fraud & Abuse section.

**Maryland Health-General Article § 2-601 through 2-611 (False Claims Against State Health Plans and State Health Programs)**

See discussion and links in False Claims/Fraud & Abuse section regarding whistleblowers for State Health Plans and Programs.

**Maryland General Provisions Article §§ 8-101, 8-102, 8-103, 8-104, 8-105, 8-106, 8-107, 8-108, 8-109, 8-110, 8-111 (False Claims Act)**

Establishes a State civil false claims act. Defines “claim,” “employee,” “employer,” “governmental entity,” “knowing or knowingly,” “material,” “obligation,” “public body,” “retaliatory action,” and “supervisor.”

**Definition of Claim**
"Claim" is defined as a request or demand, under a contract or otherwise, for money or other property, whether or not the governmental entity has title to the money or property, that is:

1. Presented to an officer, employee, or agent of a governmental entity; or
(2) Made to a contractor, grantee, or other recipient, if the money or other property is to be spent or used on a governmental entity’s behalf or to advance an interest of a governmental entity, and the governmental entity: (a) provides or has provided any portion of the money or other property requested or demanded; or (b) will reimburse the contractor, grantee, or other recipient for any portion of the money or other property that is requested or demanded.

Prohibitions
Prohibits a person from doing any of the following:

(1) Knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval;
(2) Knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim;
(3) Conspiring to commit a violation of this False Claims Act;
(4) Having possession, custody, or control of money or other property used or to be used by or on behalf of a governmental entity and knowingly delivering or causing to be delivered to the governmental entity less than all of that money or other property;
(5) (a) Being authorized to make or deliver a receipt or other document certifying receipt of money or other property used or to be used by a governmental entity; and (b) making or delivering a receipt or document knowing that the information contained in the receipt or document is not true;
(6) Knowingly buying or receiving as a pledge of an obligation or debt publicly owned property from an officer, employee, or agent of a governmental entity who lawfully may not sell or pledge the property;
(7) Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or other property to a governmental entity;
(8) Knowingly concealing, or knowingly and improperly avoiding or decreasing, an obligation to pay or transmit money or other property to a governmental entity, including misrepresenting the time at which a trade was made to make the transaction appear less favorable; or
(9) Knowingly making any other false or fraudulent claim against a governmental entity.

Civil Penalties
Provides for civil penalties of $10,000 per violation plus treble damages. Total civil penalty owed for a violation may not be less than amount of the actual damages sustained by the governmental entity. These penalties are in addition to any criminal, civil, or administrative penalties provided under any State or federal statute or regulation.
Criteria for Assessing Penalties
Establishes criteria for determining severity of the civil penalties to be assessed, including number, nature, and severity of violations; history of previous violations; degree of loss suffered by the governmental entity; history of billing compliance; whether the violator has a compliance plan in place; corrective action already taken; any funds previously returned to the governmental entity by the violator in compliance with federal requirements regarding overpayments; and whether the violator self-reported, timeliness of self-reporting, cooperated in the investigation, and if the violator had prior knowledge of the investigation.

Civil Action by the State
A governmental entity is authorized to file a civil action against a violator to seek the civil penalties detailed above, but only if it has not already filed a civil action based on the same underlying act under Maryland Health-General § 2-603 (False Claims Against State Health Plans and State Health Programs) or sought enforcement by the Maryland Attorney General under §§ 11-205 or 11-205.1 of the State Finance and Procurement Article.

Whistleblower Action and Protections
Provides for qui tam action and award of between 15–25% of proceeds of action or settlement (proportional to the time and effort of the whistleblower) if the State intervenes, along with reimbursement of expenses and attorneys’ fees. Reduces the proceeds to not more than 10% if the court finds that the action is based primarily on disclosures of specific information relating to allegations or transactions in a criminal, civil, or administrative hearing, legislative or administrative report, hearing, audit, news media, or investigation. Reduces proceeds for whistleblowers later found to have planned, initiated, or otherwise deliberately participated in the violation that the qui tam case is based upon. Dismisses from the qui tam case and can require repayment of proceeds by any whistleblower later convicted of criminal conduct in connection with the action that the qui tam case is based upon. Creates statute of limitations of later of six years after occurrence of violation, or three years after date when facts material to the right of action are known (or reasonably should have been known) by the relator or the government entity responsible for acting, but no later than ten years after the date of the underlying violation. Prohibits retaliation against whistleblowers and provides whistleblowers with a right to file civil action against employers who retaliate against whistleblowers. Restricts qui tam actions by current or former public employees or officials based upon allegations, which the employee or official had an existing duty to report or investigate or information or records that the person had access to as a result of public employment or office; actions based on allegations or transactions that are subject to a proceeding in which the governmental entity is already a party; actions based on public disclosure of allegations, and actions by State employed auditors, investigators, attorneys, financial officers, or contracting officers regarding information learned while working in that capacity. Provides that a defendant may be awarded attorneys’ fees and expenses if the defendant prevails in the case and the court finds that the
whistleblower initiated the qui tam case to harass the defendant or otherwise in bad faith.

*Annual Reports to General Assembly*
Requires annual reports to the General Assembly regarding civil actions filed under the statute.

6) **HELPFUL LINKS**
- Maryland Attorney General
- Maryland Department of Health
- Maryland Board of Physicians