WASHINGTON: Summary of Fraud and Abuse Statutes and Regulations

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1) ANTI-KICKBACK

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of ch. 18.130 Wash. Rev. Code (Uniform Disciplinary Act for Health Professions):

Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

**Medicaid Program**
**Wash. Rev. Code 74.09.240(1), (2), and (4)**
Prohibits a person, including any corporation, from soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for or as an inducement to referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made by the Washington Medicaid program.

Also prohibits soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for or as an inducement to purchasing, leasing, ordering, or arranging
for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made by the Washington Medicaid program.

Exceptions for a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity, and for amounts paid by an employer to an employee for employment in the provision of covered items or services.

Violation of Wash. Rev. Code 74.09.240(1) or (2) is a felony and punishable by a fine of up to $25,000. The penalty provisions supersede the criminal provisions of Wash. Rev. Code ch. 19.68 (see below) but do not preclude administrative proceedings thereunder.

**Labor and Industries**

**Wash. Rev. Code 51.48.280**

With limited exceptions, prohibits a person, firm, corporation, partnership, association, agency, institution, or other legal entity from soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for or as an inducement to referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made pursuant to Washington’s Industrial Insurance Program.

Also prohibits soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for or as an inducement to purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made pursuant to Washington’s Industrial Insurance Program.

Exceptions for a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity, and for amounts paid by an employer to an employee for employment in the provision of covered items or services.

A violation of the Industrial Insurance Program Anti-Kickback Statute is generally a felony (see exception below) and is punishable by a fine of up to $25,000.

Prohibits certain health services providers from charging a claimant a percentage of the claimant’s benefits or other fee for acting as the claimant’s representative for the purpose of obtaining authorization for the services. A violation of this provision is a gross misdemeanor.
2) SELF-REFERRAL

**Wash. Rev. Code 74.09.240(3)**
Prohibits physicians from self-referring a Medicaid client for certain “designated health services” to a facility in which the physician or an immediate family member has a financial relationship, including either a compensation arrangement or an ownership or investment interest. Designated health services means: (1) clinical laboratory services; (2) physical therapy services; (3) occupational therapy services; (4) radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services; (5) durable medical equipment and supplies; (6) parenteral and enteral nutrients equipment and supplies; (7) prosthetics, orthotics, and prosthetic devices; (8) home health services; (9) outpatient prescription drugs; (10) inpatient and outpatient hospital services; and (11) radiation therapy services and supplies.


3) FALSE CLAIMS AND STATEMENTS

**Wash. Rev. Code 48.80.030**
Prohibits a person from making or presenting or causing to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false. Prohibits a person from knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Also prohibits a person from knowingly making a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates the statute is a separate violation.

Prohibits a person from concealing the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service. Also prohibits a person from concealing or failing to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.

Prohibits a provider from willfully collecting or attempting to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payer to which the provider is a party.

Violation of the statute is a felony.
The statute does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees.

**Wash. Rev. Code 74.09.210**

A person or entity, but not including an individual public assistance recipient of health care, who obtains or attempts to obtain benefits or payments from a state health care benefit program in an amount greater than that to which the person or entity is entitled by means of willful false statements; willful misrepresentation or concealment of any material facts; or any fraudulent scheme (including billing for items or services not provided or of lower quality, misrepresenting the items billed, or repeatedly billing for purportedly covered items, which were in fact not covered) must repay the amounts wrongfully obtained plus interest and may be subject to a civil penalty in an amount up to three times the amount of the excess benefits or payments received.

A person can be civilly liable under this statute without any criminal action taken against him or her. All civil penalties are deposited into the Medicaid fraud penalty account, and the attorney general may contract with private attorneys and local governments as necessary when bringing actions.

**Wash. Rev. Code 74.09.220**

A person or entity, but not including an individual public assistance recipient of health care, who obtains benefits or payments from a state health care benefit program that the person or entity is not entitled to, or in an amount greater than that to which the person or entity is entitled, must repay any excess benefits or payments received plus interest.

**Wash. Rev. Code 74.09.230**

Prohibits a person, including any corporation, from knowingly making or causing to be made any false statement or representation of a material fact in any application for any payment under any state medical care program. Also prohibits a person from knowingly making or causing to be made any false statement or representation of a material fact for use in determining rights to payment under any state medical care program, or knowingly falsifying, concealing, or covering up by any trick, scheme, or device a material fact in connection with such application or payment. Prohibits a person, including any corporation, having knowledge of the occurrence of any event affecting either the initial or continued right to any payment, or the initial or continued right to any such payment of any other individual in whose behalf he has applied for or is receiving such payment, from concealing or failing to disclose such event with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized.

Violation of the statute is a felony punishable by a fine of not more than $25,000.
Case Law

This case involved the prosecution of a physician for theft and submitting false medical claims to the Medicaid program in violation of Wash. Rev. Code 74.09.230. The defendant physician claimed that he was not responsible for the billing practices of a medical clinic although he owned the clinic building and was the senior partner practicing there. The court held that although there was no direct evidence that the defendant directed that billings be handled in a manner that violated the statute, there was sufficient evidence to submit the matter to the jury.

This case involved the prosecution of a caregiver for theft and submitting false medical claims to the Medicaid program in violation of Wash. Rev. Code 74.09.230. The defendant claimed that there was not sufficient evidence to support a conviction for Medicaid fraud because the state only proved that time sheets she submitted were inaccurate, and the time sheets were not relied upon in her application for payment because they were submitted after payment. The court upheld the jury’s verdict, pointing out that the time sheets provided circumstantial evidence sufficient to prove that the defendant knowingly made false claims in her telephonic invoices. The court also held that the statutes criminalizing first-degree theft and Medicaid fraud were not concurrent and did not constitute the same criminal conduct for sentencing purposes.

This case involved the prosecution of a caregiver for theft and submitting false medical claims to the Medicaid program in violation of Wash. Rev. Code 74.09.230. The defendant claimed that the trial court violated her right against double jeopardy because the two false claim offenses merged with the conviction for theft in the first degree. The court held that double jeopardy was not violated because the statutes have independent purposes.

**Wash. Rev. Code 74.09.250**
Makes it a felony for a person, including any corporation, to knowingly make or cause to be made, or induce or seek to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility so that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, nursing facility, or home health agency, subject to a fine of not more than $5,000.

**Wash. Rev. Code 74.09.290**
Authorizes the Secretary of the Department of Social and Health Services or the Director of the Washington State Health Care Authority to conduct audits and investigations of providers of medical and other services furnished pursuant to any state medical care program. Any overpayment discovered as a result of an audit of a provider is to be offset by any underpayments discovered in that same audit sample. To determine the provider's actual, usual, customary, or prevailing charges, the
Secretary or Director may examine such random representative records as necessary to show accounts billed and accounts received.

Case Law  
This case involved an order from a state court quashing a subpoena issued to the respondent physicians seeking certain medical records of Medicaid patients. In pertinent part, the Washington Supreme Court held that physician-patient privilege was not applicable to the: (1) Department of Social and Health Services’ audit of medical records of Medicaid recipients; (2) Department’s subpoena directed to the administrator of a clinic had to be limited to the records made by the clinic in the course of furnishing Medicaid services to named patients and as so restricted was enforceable; and (3) Department’s subpoena directed to doctors operating a medical laboratory to produce laboratory test orders and corresponding test results for named Medicaid recipients during a certain period of time, could be enforced as issued.

**Wash. Rev. Code 74.09.300**  
Authorizes the Secretary of the Department of Social and Health Services or the Director of the Washington State Health Care Authority to give written notice to the appropriate licensing agency or disciplinary board of any civil penalties imposed or any termination or suspension of a provider’s eligibility to participate any state medical care program.

**Medicaid Fraud False Claims Act**  
*Wash. Rev. Code 74.66.020*  
Generally, a person is liable to the government entity for a civil penalty, plus three times the amount of damages that the government entity sustains because of that person’s act, if the person: knowingly presents, or causes to be presented, a false or fraudulent Medicaid claim for payment or approval; knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent Medicaid claim; has possession or control of property or money used, or to be used, by the government entity and knowingly delivers, or causes to be delivered, less than all of that money or property; is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and with intent to defraud, makes or delivers the receipt without completely knowing that the information on the receipt is true; knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government entity who lawfully may not sell or pledge property; knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to transmit money or property to the government entity, or knowingly conceals, avoids, or decreases an obligation to transmit money or property to the government entity; or conspires to commit the aforementioned violation(s).

The court may assess not less than two times the amount of damages that the
government entity sustains, if the court finds that: the person furnished the state Attorney General with all information known about the violation within 30 days after first obtaining the information; the person fully cooperated with the Attorney General's investigation; and when the person furnished the Attorney General with the information, no criminal prosecution, civil action, or administrative action had commenced under the Medicaid Fraud False Claims Act with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

The Attorney General’s office must, by rule, annually adjust the civil penalties so that they are equivalent to the civil penalties provided under the Federal False Claims Act.

**Medicaid Fraud False Claims Act**
**Wash. Rev. Code 74.66.050**
A person (qui tam relator) may bring a civil action in the name of the government entity (qui tam action) for a violation of Wash. Rev. Code 74.66.020 of the Medicaid Fraud False Claims Act. The relator must serve a copy of the complaint and written disclosure of substantially all material evidence on the Attorney General. The relator must file the complaint in camera. The complaint must remain under seal for at least 60 days, and may not be served on the defendant until the court so orders. The Attorney General may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence. If the Attorney General does not proceed with the action prior to the expiration of the 60-day period or any extensions obtained, then the relator has the right to conduct the action.

**Medicaid Fraud False Claims Act**
**Wash. Rev. Code 74.66.070**
Generally, if the Attorney General proceeds with a qui tam action under the Medicaid Fraud False Claims Act, the relator must receive between 15% and 25% of the proceeds, based on the extent of the relator’s contribution. When the action is one that the court finds to be based primarily on disclosures of specific information not provided by the relator, the court may award an amount of up to 10% of the proceeds, taking into account the significance of the information and the role of the relator. If the Attorney General does not proceed with a qui tam action, the relator shall receive an amount that the court decides is reasonable of between 25% and 30% of the proceeds.

**Wash. Rev. Code 51.48.250**
A person or entity, but not including an industrially injured recipient of a health service, who obtains or attempts to obtain payment under the Industrial Insurance Program in an amount greater than that to which the person or entity is entitled by means of willful false statements; willful misrepresentation or concealment of any material facts; or any fraudulent scheme (including billing for items or services not provided or of a lower quality, misrepresenting the items billed, or repeatedly billing for purportedly covered items, which were in fact not covered) must repay the
amounts wrongfully obtained plus interest and may be subject to a civil penalty in an amount not to exceed the greater of $1,000 or to three times the amount of the excess payments received.

**Wash. Rev. Code 51.48.270**
Makes it a felony for a person or entity, but not an injured worker or beneficiary, to knowingly make or cause to be made any false statement or representation of a material fact for use in any application for or determining rights to payment from the Industrial Insurance Program or knowingly falsify, conceal, or cover up by any trick, scheme, or device a material fact in connection with any such application or payment. Also makes it a felony for a person with knowledge of the occurrence of any event affecting either the initial or continued right to any payment to conceal or fail to disclose such event with an intent fraudulently to secure payment either in a greater amount or quantity that is due or when no such payment is authorized under the Industrial Insurance program. The fine for violation of the statute shall be not more than $25,000.

4) **ANTI-REBATE/FEE SPLITTING**

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of ch. 18.130 Wash. Rev. Code (Uniform Disciplinary Act for Health Professions): Violation of ch. 19.68 Wash. Rev. Code (see below).

**Guidance Document**

*Op. Att’y Gen. 1988 No. 28*
The Washington state Attorney General evaluated a question posed by the State Medical Disciplinary Board to determine whether a violation of ch. 19.68 Wash. Rev. Code, and in turn, Wash. Rev. Code 18.130.180(21) could be found. The question involved an agreement between an optometrist and an ophthalmologist whereby the optometrist referred patients to the ophthalmologist for surgery with the understanding that the referring optometrist would provide all post-operative care. Under the agreement, neither the optometrist nor the ophthalmologist would receive a profit for services other than those they themselves rendered. Because the referral did not result in any hidden or inflated charges, unnecessary surgery, or profits for services not rendered by the referring provider, the arrangement, alone, did not create any rebate or unearned charges.

**Wash. Rev. Code 19.68.010**
Makes it unlawful to pay, or offer to pay or allow, directly or indirectly, to any physician, dentist, or pharmacist, and for any such person to request, receive, or allow, directly or indirectly, a rebate, refund, commission, unearned discount, profit by means of a credit, or other valuable consideration in connection with the referral of patients to any person, firm, corporation, or association, or in connection with the...
furnishings of medical, surgical, or dental care, diagnosis, treatment, or service, on the sale, rental, furnishing, or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services, or supplies prescribed for medical diagnosis, care, or treatment.

Creates an exception for financial interest in any firm, corporation, or association that furnishes clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis where the referring practitioner affirmatively discloses to the patient in writing, the fact that such practitioner has such financial interest and provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities.

Violation of the statute is a misdemeanor.

Case Law

_Day v. Inland Empire Optical, 76 Wash.2d 407, 456 P.2d 101 (1969)._ The _Inland Empire_ case involved a challenge by a group of physicians and a corporate optician to the practice of defendant physicians who allegedly benefited from a referral relationship with an adjacent optical shop, which the defendants owned and controlled. The court held that it was permissible for the defendant physicians to own stock in a dispensing optical shop provided they did not attempt to refer patients to the shop, directly or indirectly, by sign, symbol, gesture, or physical arrangement of their offices.

_Wright v. Jeckle, 158 Wash. 2d 375, 144 P.3d 301 (2006)._ The plaintiffs challenged the physician’s practice of dispensing, at a profit, certain prescription drugs to his patients. The trial court had found that the defendant violated Wash. Rev. Code 19.68.010 by profiting on the sale of prescription drugs to his patients. The state supreme court reversed and concluded that the statute prohibits kickbacks, not profits, despite the use of the word “profit” in the statute. The court noted that although the statute was “not a model of clarity,” it prohibits two things: paying anything of value in return for a referral and receiving anything of value in return for referring patients.

_Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Associates, P.L.L.C., 168 Wash.2d 421, 228 P.3d 1260 (2010)._ The plaintiffs alleged that a professional limited liability company (PLLC) owned by licensed physicians violated the anti-rebate statute by employing physical therapists. The court held that the PLLC did not violate the anti-rebate statute by employing physical therapists to whom physicians referred patients, as the anti-rebate statute exempted from its coverage profits earned by an employee of a firm and flowing to the firm’s owners provided the owners practice in the firm. Although physical therapists alleging PLLC violated the statute asserted that physicians did not
supervise the physical therapists employed by the PLLC, the court held the anti-rebate statute did not contain a supervision requirement.

**Guidance Documents**

In this opinion the Washington state Attorney General interpreted the state’s anti-rebate statute not to preclude an agreement between an optometrist and an ophthalmologist whereby the optometrist refers a patient to the ophthalmologist for surgery with the understanding that the referring optometrist will provide post-operative care, so long as each party performs services he or she is licensed to perform and bills only for those services.

The Washington state Attorney General opined that a violation of Wash. Rev. Code 19.68.010 would be found where: (1) a payment of a rebate, refund, commission, unearned discount, or profit by means of credit or other valuable consideration has been made; (2) the payment was in connection with the referral of patients or in connection with the furnishing of medical, surgical, or dental care, diagnosis, treatment, or service; and (3) the recipient of the payment was a person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy.

In this opinion, the Washington state Attorney General interpreted the state’s anti-rebate statute to allow a physician to enter into an arrangement with a company to receive a set fee from an infusion therapy company for providing various services to the company’s customers so long as the physician actually provides the services and the fee paid reflects the fair market value for the services furnished.

State Representative Eileen Cody (D) requested an opinion to examine the practice of physicians billing patients or insurers for services provided by independently practicing pathologists to whom they referred patients. She was aware that pathologists were indirectly billing for their services by sending bills to referring physicians who would then charge patients or insurers. In some instances, physicians charged patients amounts greater than they paid to pathologists for the service.

The opinion letter asserted that ch. 19.68 Wash. Rev. Code prohibits referring physicians under indirect billing arrangements from charging patients or insurers for services performed or supervised by a pathologist an amount greater than the pathologist charged the referring physician for those services (where the pathologist is neither employed nor supervised by the referring physician). Still, physicians may charge for services related to the diagnostic screening that they “actually render” such as taking the tissue samples for a biopsy, preparing the sample, or even shipping it to the pathologist without violating Wash. Rev. Code 19.68.010.
In this opinion, the Attorney General interpreted Washington’s anti-rebate statute to preclude a donation by a clinical laboratory to a physician for the purpose of paying a portion of the cost of software for the physician’s electronic health record system in connection with the receiving physician either continuing or establishing a referral arrangement with the donating laboratory.

Wash. Rev. Code 19.68.020
Makes it unprofessional conduct for a licensed individual to accept directly or indirectly any rebate, refund, commission, unearned discount, profit by means of a credit, or other valuable consideration as compensation for referring patients to any person, firm, corporation, or association.

Case Law

Guidance Documents

Wash. Rev. Code 19.68.030
Authorizes the revocation or suspension of a practitioner’s license if the practitioner has directly or indirectly requested, received, or participated in the division, transference, assignment, rebate, splitting, or refunding of a fee for, or has directly or indirectly requested, received, or profited by means of a credit or valuable consideration as a commission, discount, or gratuity in connection with the furnishing of medical, surgical, or dental care, diagnosis, or treatment or service, including X-ray examination and treatment, or for or in connection with the sale, rental, supplying, or furnishing of clinical laboratory service or supplies, X-ray services, or supplies, inhalation therapy service, or equipment, ambulance service, hospital, or medical supplies, physiotherapy or other therapeutic service, or equipment, artificial limbs, teeth, or eyes, orthopedic or surgical appliances or supplies, optical appliances, supplies, or equipment, devices for aid of hearing, drugs, medication, or medical supplies or any other goods, services, or supplies prescribed for medical diagnosis, care, or treatment. Creates exception for payment, not to exceed thirty-three and one-third percent of any fee received for X-ray examination, diagnosis, or treatment, to any hospital furnishing facilities for such examination, diagnosis, or treatment.

Case Law

Wash. Rev. Code 19.68.040
Licensees under ch. 19.68 Wash. Rev. Code are permitted to charge or receive compensation for professional services rendered if such services are actually
rendered by the licensee and not otherwise. This provision was explicitly not intended to prohibit two or more licensees who practice their profession as copartners to charge or collect compensation for any professional services by any member of the firm, or to prohibit a licensee who employs another licensee to charge or collect compensation for professional services rendered by the employee licensee.

**Case Law**

**Guidance Documents**
*Op. Att’y Gen. 1992 No. 30*
State Senator Cliff Bailey (R) requested an opinion to examine whether ch. 19.68 Wash. Rev. Code prohibited licensed physicians from referring their patients to an infusion therapy facility in which they were shareholders, a fact pattern similar to that found in *Day* (above). As in *Day* the opinion asserted that if, as a result of their stock ownership, the physicians received financial benefit from their referrals a court would likely find a violation of Wash. Rev. Code 19.68.010.

The opinion also addressed whether such a violation remained if the physicians supervised the work of the infusion therapy facility staff; a question implicating the provisions of Wash. Rev. Code 19.68.040. Licensed physicians are permitted to collect compensation for services that were provided by other licensees who are their employees. To fit under this exception, the physician must exercise actual and exclusive control over the performance of the staff person.

The opinion raised the question of whether a physician who supervises infusion therapy staff has even made a referral that would implicate Wash. Rev. Code 19.68.010. Resolving this question, the Attorney General stated that though the legislature failed to provide a definition of “referral” in the text of ch. 19.68 Wash. Rev. Code, the common, everyday meaning of the term includes transfers to other licensees that are made in the midst of an ongoing physician-patient relationship. Thus, a physician who is either not in exclusive supervisory control over the infusion therapy staff or who maintains a continuing physician-patient relationship may be viewed as having made prohibited referrals in violation of the anti-rebate provisions of ch. 19.68 Wash. Rev. Code.


**Wash. Rev. Code 19.68.900**
Provides that ch. 19.68 Wash. Rev. Code may not be construed to limit or prohibit the donation of electronic health record technology or other activity by any entity, including a hospital that operates a clinical laboratory, when the donation or other
activity is allowed by or does not otherwise violate the Anti-Kickback Statute or its implementing regulations.

Creates an exception for entities that principally operate as a clinical laboratory licensed or certified under section 352 of the Public Health Service Act, 42 U.S.C. Sec. 263a, or other applicable Washington law.

Guidance Documents

RCW 19.68.900 includes the following findings of legislative intent:

(1) The legislature recognized the complexity of the health care delivery system and the need to provide a clear and consistent regulatory framework to enable health care providers to manage their operations in an efficient and effective manner. The legislature also recognized that the donation of electronic health records systems reduces health care costs, promotes patient safety, and improves the quality of health care.

(2) To further the important national policy of promoting the widespread adoption of electronic health records systems, the Anti-kickback Statute and its implementing regulations contain a safe harbor that allows the donation of electronic health records systems. The Anti-kickback Statute and its implementing regulations also contain additional safe harbors to preserve a variety of other activities which, in many cases, improve access to health care. For health care entities other than clinical laboratories, the legality of all of these arrangements is currently in question.

(3) The legislature added language to chapter 19.68 RCW to clarify existing law and ensure that, except with respect to arrangements involving an entity which principally operates as a clinical laboratory, it is interpreted in a manner consistent with the Anti-kickback Statute.

As of January 21, 2018, no reported Attorney General opinions cite this section of the statute’ however, this provision was enacted largely due to a 2012 Attorney General opinion (below).


The Attorney General was asked whether, under RCW 19.68.010, a clinical laboratory licensed by the State of Washington could lawfully make a monetary donation to a physician to cover 85 percent of the software cost of that physician’s electronic health record (EHR) when the physician’s office that is the recipient of the EHR donation either continues a referral arrangement with the laboratory, or subsequently initiates an arrangement for the referral of specimens to the donating laboratory for analysis. The Attorney General concluded that such an arrangement would violate the Anti-Rebate statute. The Washington Legislature found the Attorney General’s opinion to be problematic and enacted RCW 19.68.900 in response, to promote electronic health record technology and ensure alignment with the Anti-Kickback Statute.
5) EXCESSIVE CHARGES/PAYMENTS

**Wash. Rev. Code 51.48.260**
Any person or entity, other than an industrially injured recipient of health services, who, without intent to violate Wash. Rev. Code ch. 51.48, obtains payments under the Industrial Insurance Program to which such person or entity is not entitled, is liable for any excess payments received, plus interest.

**Case Law**
**Dep’t of Labor and Indus. v. Kantor, 94 Wash. App. 764, 973 P.2d 30 (1999)**
In *Kantor*, the court held that the term “excess payments” in Wash. Rev. Code 51.48.260 includes payments that the Department of Labor and Industries (L&I) previously made for services that were not “medically necessary.”

The court in *Allen* held that L&I had statutory authority to recover excess payments received by the physician in violation of the medical aid rules and that the physician was contractually obligated to refund any excess payments he received.

In *Divorne*, a provider of hearing aids challenged his criminal conviction for theft, conspiracy, and making false statements to L&I. The court noted that, though the auditors in *Allen* and *Kantor* were physicians, neither of these cases held that the determination of “medical necessity” must be made by a physician or other similarly qualified expert medical witness, as the appellant had argued. Testimony defining medical necessity made by an L&I auditor was sufficient.

**Wash. Rev. Code 74.09.220**
Any person or entity, other than an individual public assistance recipient of health care, who, without intent to violate Wash. Rev. Code ch. 74.09, obtains benefits or payments to which such person or entity is not entitled, or in a greater amount than that to which entitled, is liable for any excess benefits or payments received, plus interest. Such penalty or interest shall not be reimbursable by the state as an allowable cost by any state health care benefit program.

**Case Law**
In *Bircumshaw*, the court of appeals held that the plain meaning of the relevant statutes (including RCW 74.09.220), regulations, and agency guidelines established that the Washington State Health Care Authority (HCA) may recoup Medicaid payments for billed services on the basis of inadequate documentation, pursuant to statutory and regulatory authority and contractual power.

In Allen Dental, the defendant argued that the relevant regulations (including RCW 74.09.220) did not require the maintenance of a chart for every patient in order to adequately document and justify services provided. The court of appeals disagreed and held that the failure to maintain adequate, authenticated patient charts as required by regulations can serve as the basis for recoupment of Medicare payments for billed services.

Wash. Rev. Code 74.09.260

Makes it a felony for a person, including any corporation, to knowingly charge for any service provided to a patient under any state medical care plan, at a rate in excess of the rates established by the Department of Social and Health Services or the Washington State Health Care Authority, as appropriate; or to charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under such plan, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) as a precondition of admitting a patient to a hospital or nursing facility or as a requirement for the patient's continued stay in such facility, when the cost of the services provided to the patient is paid for, in whole or in part, under any state medical care plan. Any fine for violation of this statute shall not exceed $25,000.

6) DISCLOSURE OF HEALTH CARE FEES AND CHARGES

Wash. Rev. Code 70.01.030

Health care providers and facilities shall provide to a patient upon request an estimate of fees and charges related to a specific service, visit, or stay, and information regarding other types of fees or charges a patient may receive in conjunction with their visit to the provider or facility.

Providers and facilities may, after disclosing estimated charges and fees to a patient, refer the patient to the patient's insurer, if applicable, for specific information on the insurer's charges and fees, any cost-sharing responsibilities required of the patient, and the network status of ancillary providers who may or may not share the same network status as the provider or facility.

Except for hospitals, providers and facilities listed in subsection (1) of this section shall post a sign in patient registration areas containing at least the following language: "Information about the estimated charges of your health services is available upon request. Please do not hesitate to ask for information."
Wash. Rev. Code 70.41.450
Hospitals shall post a sign in patient registration areas containing at least the following language: "Information about the estimated charges of your hospital services is available upon request. Please do not hesitate to ask for information."

6) HELPFUL LINKS
- Washington State Health Care Authority: Health Care Assistance in Washington State
- Washington State Medicaid Fraud Control Unit
- Washington State Department of Labor & Industries—Claims and Insurance Information for the Workers' Compensation Program