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INSIDE

Special Report: Utah Nurse Arrest

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Nurse Arrest Puts Focus on Hospital Security, Policies

The highly publicized arrest of a Utah nurse for refusing to allow a police request to draw blood on an unconscious patient drew attention to how hospital policies and procedures should protect staff in such confrontations, and particularly the role that in-house police and security officers should play.

One of the most disturbing parts of the incident — which included many shocking components — was the apparent cooperation of the hospital police and security officers in the nurse's arrest. Professionals in the healthcare, legal, and security industries agree that the actions of hospital security were troubling, as they facilitated the arrest after the nurse called them to protect her from what she perceived as a threatening and irrational local police detective.

> ONE OF THE MOST DISTURBING PARTS OF THE INCIDENT WAS THE APPARENT COOPERATION OF THE HOSPITAL POLICE AND SECURITY OFFICERS IN THE NURSE'S ARREST.

Alex Wubbels, RN, is a charge nurse at the University of Utah Hospital in Salt Lake City who was overseeing a patient who had been brought to her ward unconscious following a police chase that ended in a collision. The man being chased by the police died. The patient was a commercial truck driver whose vehicle was struck by the fleeing driver.

After the patient was transferred to Wubbels' unit with extensive burns, Salt Lake City police detective **Jeff Payne** arrived with a request for staff to draw blood from the patient, or to do it himself. Payne worked off duty as a paramedic and was

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authorized by the police department to draw blood for investigations.

Wubbels explained that she could not allow the blood draw without a warrant or the patient's permission. The detective insisted, even after Wubbels cited hospital policy and Utah state law supporting her position. After almost an hour of waiting, Payne suddenly arrested Wubbels. He grabbed her and dragged her out of the hospital as she cried and begged for help. *(See the story on page 126 for details on the arrest and the video recording.)*

Detective Threatens Retaliation

As Wubbels sat handcuffed in a police car for 20 minutes in the July heat of Utah with no air conditioning, Payne's bodycam shows him remarking to another officer that he could retaliate against the hospital in his part-time job as a paramedic. "I'll bring them all the transients and take good patients elsewhere," Payne says in the footage.

The ambulance company fired Payne for those comments. Payne and his supervisor, who had authorized the arrest and arrived on the scene after Wubbels was handcuffed to tell her she deserved the arrest, were put on administrative leave. Two investigations yielded scathing criticism of their behavior. In October, the police department fired Payne and demoted his supervisor. *(See the story on page 128 for more on the results of the police investigations.)*

Wubbels was released at the hospital and not charged. The patient at the center of the dispute died from severe burns. The police explained during the incident and afterward that he was the victim of a crime, not suspected of any wrongdoing, and they were seeking the blood test to protect him by proving he was not under the influence at the time he was hit by the person fleeing police. Federal regulations for commercial truck drivers require post-accident testing for impairment in serious accidents, even when the driver is not at fault. The patient also was a reserve police officer in Idaho.

University of Utah Hospital issued statements supporting Wubbels and standing by the hospital's policies on complying with law enforcement requests for blood draws. The hospital also announced immediately after the arrest that police officers were barred from patient care areas and that nurses would no longer deal directly with law enforcement.

"The hospital supported her wholeheartedly and is proud of her actions to put her patient's care and well-being first," says spokesperson **Suzanne Winchester**.

Intervention by hospital administration secured Wubbels'

EXECUTIVE SUMMARY

A nurse was arrested for refusing a police detective's demand to draw blood from an unconscious patient. Fallout from the incident is leading to changes at the hospital and within the police department.

- Hospital police and security guards facilitated the arrest.
- The nurse was following hospital policy, which complied with state law.
- The hospital and police department may be sued by the nurse.

release 20 minutes after she was taken into custody. Both risk management and hospital customer service were made aware of what had taken place immediately following the incident. In the 24 hours following the incident, top administrators were informed about what happened and offered Wubbels their support, Winchester says. Several hospital administrators viewed surveillance video of what had occurred and contacted university police. A meeting was arranged involving hospital administration, university police, the Salt Lake City police, and the university's general counsel.

Role of Hospital Security Questioned

The Wubbels arrest highlights the difficulty of cooperating with law enforcement while also protecting patients and complying with the law, showing that even when the hospital puts proper policies and procedures in place, the confrontation can turn ugly. In this instance, the role of hospital security is under particular scrutiny.

The university police clearly deferred to the city police officers instead of taking any action to protect the nurse.

As Wubbels sat handcuffed in a police car, Payne's bodycam video shows him commenting to another officer about the response by hospital security: "The officer and security showed up and said, 'We can't stop him. We're not going to get involved.'"

The officer says the hospital police officer did the right thing. Payne replied, "He did. He did it the correct way, which is how I would do it if he were arresting someone in Salt Lake City. I'd stand there and say, 'What do you want me to do?' And then I physically drug her out of the ER." *(Excerpts from Payne's bodycam are available online at: http://bit.ly/2kooBC9.)*

Hospital May Be Sued

Wubbels may sue both the police department and the hospital over the experience, says Wubbels' attorney **Karra J. Porter**, JD, with the law firm of Christensen & Jensen in Salt Lake City. The arrest garnered so much attention and outrage after the video went viral that many people are encouraging Wubbels to sue, she says.

Porter notes that Wubbels received a handwritten letter from the police chief in Rigby, ID, where the patient worked as a reserve police officer, thanking Wubbels for protecting the rights of her patient.

"I've heard from many, many law enforcement officers who were upset by this," Porter says. "It's consistent to be pro-law enforcement and still be outraged by what happened. But I'm equally outraged, if not more, by the conduct of the hospital personnel and administration. I find that to be almost more outrageous."

Wubbels would sue the hospital and its owner, the University of Utah, specifically for the actions of the hospital police and security officers, Porter says.

"The hospital security and university police facilitated this and they're probably going to get sued over it if they don't work out an amicable resolution," Porter says. "They actually facilitated the unlawful arrest. They did nothing to intervene, not even to de-escalate this. They could have said, 'No one is going to arrest an employee of our hospital until hospital administration gets here,' and administration was on the way down."

The University of Utah Department of Public safety includes 27 full-time sworn police officers, one reserve police officer, and 28 security officers, according to the university website.

"Alex called hospital security and said, 'Could you please protect me? This officer is threatening to arrest me,' and the hospital police and security said they couldn't do anything, and if he wanted to arrest her they were going to let him," Porter says. "When she was trying to back away, the person who stops her so the city police officer can take her and arrest her, that's a hospital police officer. He impedes her path and directly facilitates her illegal arrest, and that's why he's now a potential defendant."

In addition, another hospital security officer pushed the door open button to aid the city police detective manhandling the nurse to the hospital exit. Porter calls that affirmative action to aid the detective "appalling," an opinion echoed by others.

The nurse did exactly the right thing, following policy and maintaining her composure in a stressful situation, says **Gordon Lee Gillespie**, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN, FAAN, associate professor and deputy director of the Occupational Health Nursing Program at the University of Cincinnati. He calls Wubbels a hero. However, the university police and security guards failed miserably, he says.

"If that had been a patient dragging her out, a mental health patient or otherwise, would we have just stood there or would we have called for help, blocked the exits, done anything nonviolent to hamper him dragging her out of the hospital?"

Gillespie asks. "You don't punch the door open button. You can stand in front of it to slow the guy down, or you can go on lockdown with 10 people standing in front of every exit. The officer will have to tell them to get out of the way, and you slow that person down long enough for someone to intervene, or to let him realize what he's doing is wrong."

Porter emphasizes that the university police are sworn officers who have not only the authority, but the duty to step in and prohibit an illegal arrest or other unlawful action by another police officer. They are not in any way a lesser authority than the Salt Lake City police, she says.

"Clearly, they should have intervened, and I mean before the detective started lunging at her," Porter says. "Apparently, it was their own policy to completely defer to any outside law enforcement that steps on their property. It's odd, it violates the Constitution, and it's what gets them sued because law enforcement officers have a duty to intervene when they see unconstitutional acts taking place."

Gillespie and Porter agree that clinicians and other bystanders should not physically intervene when a police officer is arresting someone, even when the arrest is unlawful. Doing so would be dangerous and illegal, greatly escalating the situation. But other police officers are a different matter, Porter says.

"They can step in and stop it, and they have a duty to do so," Porter says.

Even if the hospital does not employ sworn police officers, or the non-sworn security guards are the only ones present at the time, the guards still should stand up for the hospital employee and insist that the police wait until hospital administration can arrive and sort out the dispute, Porter says. If the risk manager cannot directly write hospital policies regarding security, he or she should work closely with the director of security to influence those policies, Porter says.

If the same situation occurred in his hospital, **Martin Green**, CHPA, manager of security, telecommunications, and emergency preparedness at Baycrest Health Sciences hospital in Toronto, says he would have stepped up and intervened. Green also is president of the International Association for Healthcare Security and Safety (IAHSS), an organization for security and safety professionals in healthcare facilities.

There is no question that the nurse should not have been arrested, he says.

"We don't know the whole story just from watching the video, but if it happened in my hospital I think I would step forward and ask the officer to slow down and regroup a bit. This wasn't a situation where what he wanted to do had to happen this second," Green says. "I think he just got tired of debating and losing the argument, and decided to act inappropriately. It looked to me like the police officer was having a temper tantrum."

Police officers usually are reluctant to interfere with officers from another agency or jurisdiction, Green says, and that may explain the actions of the university police. They probably felt a spirit of camaraderie with the city police, more so than with the hospital staff, he says.

Green encourages hospital leaders and security officials to meet with local law enforcement and establish relationships that might help avoid such incidents, or at least provide possible solutions when confrontations develop.

"I've been in situations where I disagreed with law enforcement and I was threatened with arrest," Green says. "But I was able to tell them that before they arrest me, maybe they should call up Superintendent Smith and have a little chat with him and see if you really want to go ahead and arrest me."

Hospital and Nurse Acted Appropriately

The nurse and the hospital acted appropriately in refusing to comply with the requests and demands of the police officer without the appropriate authority to do so, says **William Hopkins**, JD, partner in the Shackelford law firm in Austin, TX. As healthcare providers, the hospital and the nurse have a heightened burden to protect the privacy of the patient who is vulnerable and under their care, he says. Since HIPAA violations are based on the release and failure to protect the information, the police were seeking to push the hospital and nurse to violate HIPAA and the patient's civil rights, he says.

"Based on what could be seen in the video, it appears that the nurse acted totally appropriately and professionally the entire time that she was dealing with the police. She took the information that the police were providing her and responded to their requests by not only telling them and showing them the policies and the law that was driving her position, she made multiple requests to them to provide her with a way that she could comply with them, without violating the policy of the hospital and the law," Hopkins says. "She did not tell them, 'No.' She told them, 'Give me a way to say yes to you.'"

The risk to the nurse and the hospital would have been significant

if she complied with the police request to avoid arrest, Hopkins says.

"If the nurse had violated her facility policy and the requirements of HIPAA, she would have clearly violated the standards of practice for a nurse and would have personally subjected herself to having her license referred to her nursing board, she could have been sued by the patient for invasion of privacy, HIPAA violations, and she could have been prosecuted for assault," Hopkins says. "The hospital would have also been subject to a lawsuit for violation of the patient's civil rights and invasion of privacy. Depending on how the hospital is certified, it could have also subjected itself to potential licensure violations at the state level or at The Joint Commission level as well."

Hopkins commends University of Utah Hospital for establishing the proper policy reflecting state law, one that apparently was vetted by the local police department. The only failing he saw involved the hospital police and security guards.

"The nurse not only had the policy handy, she was also talking to the hospital attorney on the phone seeking advice regarding how to handle the situation. I don't think there is much else that the nurse could have done," he says. "It was interesting that the hospital security guards did not feel a need to involve themselves in the process, given that all of this was happening on the hospital grounds, which is their jurisdiction."

Hospitals face a daily challenge of cooperating with police investigations while adhering to the law and protecting staff, Hopkins says. They have to strike a balance between assisting law enforcement with their job and protecting their patients.

In this case, it is apparent that the nurse wanted to cooperate with the police, and made that desire to cooperate quite clear, but they refused to understand that they had not given her any ability to cooperate with them, he says. When she provided the police officers with the policy requirements, the police should have stepped away, fulfilled one of the requirements to satisfy the policy, and then taken their blood sample.

"Instead, it appears the police sought to use coercion and force to circumvent the law, the policy, and the privacy requirements. It is arguable that the police did not care if the patient's privacy was being violated if they were not drawing the blood and the nurse was doing it," Hopkins says. "They could have turned on the nurse later and stated that if it was against the hospital policy to draw the blood, then she should not have done it. They were merely using her to get what they wanted and clearly did not care about the potential ramifications to the nurse or the hospital."

Hospital risk managers and administrators from several hospitals have contacted **Diane Robben**, JD, shareholder with the law firm of Sandberg, Phoenix & Von Gontard in St. Louis, seeking guidance after seeing video of the Utah incident. She tells them the nurse acted appropriately and they must encourage their own clinicians to stand their ground when adhering to the law.

"We're advising some of our hospitals to beef up their policies so that when they're forced into these situations, they have a good policy to rely on. That doesn't mean it makes these problems go away, but it's a starting point and gives your staff some support," she says. "This has caused a ripple in the healthcare system and a lot of people are wondering what would have happened at their own hospital. They want to at least have a solid policy in place that is compliant with the law and provides the appropriate protection to the patient and the hospital staff."

Wubbels has received an outpouring of support from nurses and other healthcare professionals, Porter says, with many of the messages suggesting others fear the same sort of incident could happen to them. They also suggest that many clinicians are not confident that their hospitals would protect them, she says.

"I think there is more concern by nurses about whether their hospitals are really committed to protecting them, than we knew," Porter says. "I'm not sure they really knew they had that concern until they saw this video and how hospital security betrayed Alex. That's what Alex says, that her own security betrayed her when she looked to them to protect her." ■

SOURCES

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Video Shows Aggressive Arrest of Nurse

The videos showing the arrest of nurse **Alex Wubbels** are disturbing to many viewers, but especially to risk managers and other healthcare professionals who understand the dilemma faced by a clinician trying to comply with hospital policy and the law when law enforcement demands otherwise.

The arrest at the University of Utah Hospital in Salt Lake City happened in July, but the videos surfaced only recently when Wubbels made public statements about her experience. *(An 18½-minute video of the arrest is available online at: http://bit.ly/2yYdJOH. Shorter clips also are available online, but portray less of the interaction before and after the actual arrest.)*

The video from another officer's bodycam begins after Salt Lake City police detective **Jeff Payne** demanded a blood draw from an unconscious burn patient on Wubbels' unit. Wubbels explained that she could not allow the blood draw without a warrant or the patient's permission, but the detective insisted and threatened to arrest her if she did not comply. At the beginning of the video, Wubbels is on the phone with the nurse manager explaining the situation, while Payne tells a colleague that his supervisor has instructed him to arrest the nurse if she does not comply.

The hospital's house supervisor is present and also on the phone with someone at this time. One hospital police officer and two hospital security officers are standing by.

Five minutes into the video, Wubbels presents Payne and the other officer with a copy of the hospital's policy on what is required to comply with a law enforcement request for a blood draw. She explains that the nurse manager instructed her to print the policy and give it to them, and she puts the nurse manager on speaker as she does so. "This is something you guys agreed to with this hospital," Wubbels says, showing the policy. "The three things that allow us to do that are if you have an electronic warrant, the patient's consent, or the patient under arrest. The patient can't consent, he's [gesturing to Payne] told me repeatedly he doesn't have a warrant, and that he is not under arrest."

Wubbels' demeanor is entirely calm and cooperative. "I'm just trying to do what I'm supposed to do. That's all," she says.

Payne asks her to confirm that if one of those requirements is not fulfilled, she is not allowing the blood draw. At that point the nurse manager can be heard telling her, "Alex, you're not representing University Hospital" and asks why Payne is blaming her. She says she doesn't know and when the nurse manager asks Payne, he responds, "She's the one that has told me no."

The nurse manager says, "Sir, you're making a huge mistake right now because you're threatening a nurse." At that moment, Payne says, "OK, we're done," and reaches for Wubbels' arm, the one she is using to hold the cellphone near Payne. Wubbels reacts by moving her arm away and stepping backward. Payne moves forward aggressively toward Wubbels as she backs away.

Payne repeats "We're done" and tells Wubbels she is under arrest. She continues backing away until she backs into one of the hospital security officers, who reaches out to her. It is not clear if the officer was trying to contain her for Payne, but he does not say or do anything to interfere with the arrest.

As Payne initially grabs Wubbels, the house supervisor says "Sir, I have administration coming."

Wubbels screams and cries out as Payne roughly grabs her by the arm and moves toward the hospital exit. One of the security guards who was present at the beginning of the video holds the exit button for the automatic doors so Payne can force Wubbels out of the building. That guard is on the phone at this point.

Wubbels becomes very emotional as she taken out of the building and clings to the exterior doorjamb as Payne prepares to handcuff her. "Someone help me! Stop! You're assaulting me! I've done nothing wrong!" she sobs.

The house supervisor and a hospital police officer follow them outside, the supervisor saying something to the guard as they walk. The hospital police officer puts his hand on Payne's shoulder and says something but immediately backs away. The house supervisor again explains to Payne that a hospital administrator is on the way. Another hospital employee appears and tells Payne the arrest is unnecessary.

Once Wubbels is handcuffed, she looks to the officer recording the incident and says, "Why is he so angry?"

Payne forces Wubbels to his car. When she screams that he is hurting her, Payne says, "Then walk!" She says again that he is hurting her and looks to the house supervisor in tears, saying, "What is going on? What is going on?"

Payne places Wubbels in his police

car. His supervisor arrives and speaks to Wubbels, telling her that the hospital policy must yield to a legal demand from law enforcement. The nurse explains that she was following her employer's instructions and trying to protect her patient, and that the blood test they want wouldn't be valid anyway because the patient received medications for comfort.

"If we're doing wrong, there are civil remedies," the supervising officer says. "It's called fruit of the poisonous tree. If we take his blood illegally, it all goes away. So, there are civil remedies if we make a mistake. What I'm telling you is we are not making a mistake."

He then discusses the legal requirements more, disagreeing with Wubbels' understanding of the law. Wubbels repeats that she was only following the orders of her hospital superiors. He asks her if she knows whether the patient was a resident of Utah, and when she says she has no idea, he gets exasperated and says, "So, why are you involved in this? You don't have anything to do with this!"

Wubbels calmly replies, "Because I'm the charge nurse of the unit where he was admitted."

The supervising officer finishes speaking to Wubbels and the house supervisor asks if he will speak to the hospital privacy officer on the phone. He refuses, saying he doesn't need another reiteration of a policy intended to protect the hospital from liability.

"Your policy is contravening what I need legally," he says. "There is a very bad habit up here of your policy interfering with my law." ■

Hospital Revises Policy on Police Requests

The University of Utah Hospital continues to refine its policies for encounters with law enforcement, recently rolling out a new policy that requires police to go through the hospital's customer service office with any request.

The customer service office will page the hospital's house supervisor, who will respond with the university police officer who normally is present in the ED. "The officer will explain their needs, present any legal process (i.e., search warrant), if applicable, and complete the Law Enforcement Not In Custody Patient Access Form," the policy states. "The House Supervisor will facilitate the officer's needs, as appropriate. If there is disagreement between the officer and the House Supervisor, both parties shall contact their respective supervisors to facilitate resolution."

The policy says patients in police custody will be guarded in compliance with existing policies, but it does not address disputes regarding blood draws or other access. If a patient is not in custody but police want to place the patient in custody, they must go through the customer service department and a house supervisor to gain access.

Noting that interactions between police personnel and ED staff are inherently different from other areas of the hospital, the policy states that law enforcement must notify the university police officer stationed in the ED and the charge nurse when they enter. If there is disagreement between officers and ED personnel about the officer's request for patient access or information, the hospital house supervisor will be paged and respond.

"Officers and Emergency Department personnel shall not argue to resolve the issue, and will wait to resolve any problems that arise with the House Supervisor. If the situation cannot be resolved between the officer and the House Supervisor, both parties shall contact their respective supervisors to facilitate resolution," according to the policy. "The University Police Officer will advocate that all parties involved follow these procedures."

Attorney **Karra J. Porter**, JD, with the law firm of Christensen & Jensen in Salt Lake City, notes that the Salt Lake City police officials agreed to abide by the new policy, but they also had agreed to the policy that her client, Alex Wubbels, RN, was trying to follow when arrested.

Porter also says that although the hospital claims to fully support Wubbels, the new policy seems to suggest the nurse is to blame for the incident.

When she pointed out that the house supervisor was at Wubbels' side the whole time and referring police to that person wouldn't change anything, Porter says hospitals leaders responded that they would make sure the house supervisor was well trained to handle such situations.

"So, I told them they were suggesting Alex did something wrong, something that with better training she would do differently," Porter says. "I feel like they are blaming Alex with this new policy."

A policy prohibiting law enforcement from working directly with clinicians would not be effective for many hospitals, says **Gordon Lee**

Gillespie, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN, FAAN, associate professor and deputy director of the Occupational Health Nursing Program at the University of Cincinnati. Smaller and more rural hospitals might not have a senior administrator available at all times, and getting one to the hospital might take an hour or more, he says.

"When the nurse calls the administrator on the phone, and the police officer is telling you to hang up and do what he asked for, then what? It's a good idea to not have the nurse involved, but that nurse is going to be involved if the officer shows up on the unit and says he's going to draw blood from your patient," he says. "And what does the nurse do when the administrator on the phone says no and the police officer is still standing there saying he doesn't care and he still wants that blood draw?"

In such situations, clinicians must be able to escalate through the chain of command quickly, Gillespie says. That means not waiting for an administrator to return a phone call in 10 minutes. If the first is not immediately available, the clinician should be able to move to the next higher administrator.

"If that means calling the hospital president at 3 a.m., the clinician should be empowered to do that," he says. "This is a special circumstance when you have an armed officer acting irrationally and threatening a nurse, so standard administrative procedures may not be enough. You have to have procedures in place for the nurse who is suddenly in that terrible situation." ■

Scathing Results from Police Investigations of Nurse Arrest

The Salt Lake City Police Department conducted two separate investigations of the arrest of nurse Alex Wubbels, RN, and the results echo the reactions of many who have seen the videos.

Detective Jeff Payne's actions were "inappropriate, unreasonable, unwarranted, disrespectful," according to a report from the department's internal affairs division. Payne and his supervisor, Lt. James Tracy, violated numerous department policies and ethics rules, investigators found.

Salt Lake City Mayor Jackie Biskupski announced the findings of that investigation and another by the city's independent Police Civilian Review Board, which reached similar conclusions. A criminal investigation by the Unified Police Department, the FBI, and the Salt Lake County District Attorney's Office continues.

The internal affairs investigation found that both officers violated five policies: conduct unbecoming of an officer; courtesy in public contacts; a policy that states misdemeanor citations should be used instead of arrest "whenever possible;" violation of the department's law enforcement code of ethics; and a city-mandated standards of conduct policy.

Payne's conduct was "inappropriate, unreasonable, unwarranted, discourteous, disrespectful, and has brought significant disrepute on both you as a police officer and on the department as a whole," according to the report.

"You demonstrated extremely poor professional judgment (especially for an officer with 27 years of experience), which calls into question your ability to effectively serve the public and the department in a manner that inspires the requisite trust, respect, and confidence," the report adds.

Similar criticism was aimed at Tracy, with the report saying his behavior was "discourteous and damages the positive working relationships the department has worked hard to establish with the hospital and other healthcare providers."

Neither Tracy nor Payne fully understood current blood draw laws or hospital policies, and unlike the nurse they arrested, did not seek legal clarification from the department's attorneys or superiors, the Civilian Review Board report says. It also notes that Payne clearly "lost control of his emotions" and self-control, yet none of the Salt Lake City or University of Utah law enforcement officers intervened.

The mayor said she did not know of the incident until Wubbels released the policy bodycam video obtained by her attorney and made public statements about her experience. Salt Lake City police claim the internal affairs investigation began within 24 hours of the incident, but the officers were not placed on leave until the day after the video was released months later. ■

ASC 606 Standard Requires Proper Reporting of Revenue

The Department of Justice's (DOJ's) campaign against healthcare fraud puts hospitals and health systems at risk in many ways, and they could find themselves subject to even greater fraud risk as the 2018 compliance deadline for a new standard of revenue reporting fast approaches.

The standard, "ASC 606, Revenue From Contracts With Customers," is aimed at providing investors a more streamlined and accurate picture of revenues and requires entities to determine revenue recognition based on five steps, says **Venson Wallin**, CPA, managing director with the Richmond, VA, office of the BDO consulting firm.

The new standard will become part of the DOJ's continued focus on healthcare fraud, Wallin says.

"For every dollar they spend on fraud detection and enforcement activities, they get $6 back in the form of fines and penalties," Wallin says. "That is all the incentive they need to continue expanding their investigations for fraud, whether it is intentional or unintentional."

The intense DOJ scrutiny comes at a time when the industry is moving toward more value-based reimbursement, particularly with Medicare, Wallin notes. Diverse revenue streams can be difficult to portray in financial statements, setting up the possibility that information can be inadvertently misleading.

The rules are complex enough that healthcare organizations can be noncompliant without meaning to, or even give the impression of fraud when none exists, Wallin says. Investigators are making heavy use of data analytics, so healthcare organizations should expect special scrutiny in any outlier areas, he says.

> "YOU NEED TO BE PREPARED WHEN INVESTIGATORS SHOW UP AND SAY YOUR DATA IS WAY OUT OF LINE AND THEY THINK THERE MAY BE SOME FRAUD HERE."

"Understand if you are an outlier in any area, you should understand why you are," he says. "Chances are you're going to get some inquiries from the government about those outlier areas, and being able to explain why can make a real difference in what happens. If you have an acuity level for claims that is higher than average because other hospitals send you their sickest patients, it is extremely important that you know that is in your data and why that is so. You need to be prepared when investigators show up and say your data is way out of line and they think there may be some fraud here."

Because the ASC 606 rule is new, there are unanswered questions about compliance, says **Steven Shill**, CPA, partner and national leader with the BDO Center for Healthcare Excellence and Innovation in Orange County, CA.

"We will have to wait and see how revenue and revenue accounting will be interpreted, so I think there will be a great number of outliers until that is settled," Shill says. "It's going to take a couple of years for that to settle down."

The third step in complying with ASC 606 is determining the transaction price — and that presents significant challenges for healthcare, particularly provider CFOs, in the value-based reimbursement environment, Shill says. The previous methodology for determining a transaction price was more forgiving, he explains.

"Previously, if you made an estimation based on the best available information, then you couldn't be held responsible necessarily for making a bad estimate," he says. "The new accounting literature says you have to estimate to a level of precision that revenue isn't going to

EXECUTIVE SUMMARY

A new financial rule puts hospitals at risk for charges of fraud. The rule, known as ASC 606, addresses revenue recognition by healthcare organizations.

- The rule will be enforced as part of the federal government's ongoing crackdown on healthcare fraud.
- Poor compliance may inadvertently suggest fraud where none exists.
- Fraud and noncompliance may be found in reviewing mergers and acquisitions.

reverse out to any extent in the near future. That raises the bar to a much higher level, which will initially result in a lot of judgments being made and a lot of finger-pointing."

In addition, fraud and abuse can be discovered by chance when auditors examine contracts or plans for mergers and acquisitions, he says. For example, referral kickbacks or inappropriate payments to vendors can be hidden with misleading revenue recognition, Shill says.

"Some of the complexities of this rule could be used by less-than-honorable providers or operators in the healthcare industry to essentially hide or conceal aspects of Medicare fraud and abuse. We have a rapidly changing reimbursement environment and a relatively unknown new piece of accounting literature that is raising a lot of questions and creating a stir in the industry," Shill says. "It creates the opportunity for the perfect storm. The industry needs to take heed that there is a confluence of events that is likely to create issues in the next few years." ■

SOURCES

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- **Venson Wallin**, CPA, Managing Director, BDO, Richmond, VA. Phone: (804) 614-1188. Email: vwallin@bdo.com.

OIG Auditing Medicare Payments for Telehealth

Healthcare organizations offering telehealth services should expect more scrutiny from the federal government now that the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has announced plans to review Medicare payments for telehealth services, seeking to confirm the patient was at an eligible originating site and that the statutory conditions for coverage were met.

"To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site," OIG explains in a supplement to its 2017 Work Plan. "An eligible originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office. We will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements."

Increased Scrutiny May Mean Greater Clarity

The increased scrutiny is not necessarily reason for concern, says **Nathaniel M. Lacktman**, JD, partner with the law firm of Foley & Lardner in Tampa, FL. Healthcare organizations should consider the audits one more reason to ensure compliance with the Medicare rules on telehealth, but the audit program is not expected to be particularly onerous or risky, he says.

Eventually, the OIG focus on telehealth compliance will yield clarification on any questions and make compliance easier, he says.

"We're seeing a bit more growth and utilization of telehealth in the Medicare program, which clearly is lagging behind state Medicaid programs and commercial payers in the types of telehealth it covers," Lacktman says. "Providers are getting more confident and submitting more claims to Medicare for those services, so that triggers a need for a review."

Site Fees Not Always Clear

Medicare pays for telehealth services in two ways — the distant site fee, which covers the professional fee for the remote physician or nurse practitioner delivering the service, and the originating site fee, which reimburses the facility where the

EXECUTIVE SUMMARY

The federal government will audit Medicare payments for telehealth services. One focus is confirming that the patient was at an eligible site.

- Medicare is seeing more claims for telehealth services.
- There are gaps in the number of claims for distant sites and originating sites.
- The gaps may indicate that the originating site was ineligible.

patient is located. Typically, the originating site fee is about $25.

HHS has clarified that it is not necessary that claims be filed for both reimbursement opportunities, Lacktman says. If a claim is filed for the distant site fee but not the originating site fee, Medicare still can pay the distant site fee.

For instance, the originating site may not file for reimbursement because the $25 is not worth the time and effort. But Medicare has noted a gap in the types of claims filed and theorized that some of those gaps may be due to the ineligibility of the originating site, such as the patient's home. That would invalidate the claim for the distant site.

"That's what the OIG audit is really intended to investigate," Lacktman says. "They will be looking at the other requirements as well, but that gap in those types of claims is prompting their curiosity because the location of the patient is the one factor that is not obvious from the claims documentation."

To help understand the telehealth requirements for Medicare, HHS offers a Telehealth Payment Eligibility Analyzer available online at: http://bit.ly/2jIvFZO.

"Medicare providers should continue to bill Medicare for telehealth services that are covered, and they should make sure they fully understand the eligibility requirements," Lacktman says. "This actually represents a growth for telehealth. Auditing the claims is a sign that Medicare is moving to embrace it more and bring telehealth more in to the mainstream." ■

SOURCE

- Nathaniel M. Lacktman, JD, Partner, Foley & Lardner, Tampa, FL. Phone: (813) 225-4127. Email: nlacktman@foley.com.

CME/CE QUESTIONS

1. **In the incident involving the arrest of Alex Wubbels, RN, at the University of Utah Hospital in Salt Lake City, why did she refuse the police request for a blood draw?**

   a. She did not know the police detective making the request.
   b. She did not have the ability to grant the request, regardless of whether legal conditions had been met.
   c. The request did not meet the legal conditions for obtaining blood from an unconscious patient who was not in custody.
   d. The patient's injuries and treatment status made it impossible to draw blood.

2. **What happened to Wubbels after the arrest?**

   a. She was released after about 20 minutes when a hospital administrator arrived, and she was not charged.
   b. She was taken to the police station and charged with interfering with a police investigation.
   c. She was charged with interfering with a police investigation, but released while at the hospital.
   d. She was released and not charged, but the hospital dismissed her for her actions.

3. **Which of the following is part of University of Utah Hospital's new policy on law enforcement requests?**

   a. Nurses are to comply with law enforcement requests and later report any concerns to administration.
   b. Police officers are to initiate requests through the hospital's customer service department and will not deal directly with clinicians.
   c. Police officers must submit all requests in writing to hospital's general counsel and allow 24 hours for a response.
   d. Police officers are no longer allowed on hospital property except in emergencies.

4. **What happens if a healthcare provider bills Medicare for the telehealth distant site fee, which covers the professional fee for the remote physician or nurse practitioner delivering the service, but the facility where the patient is located does not bill for the originating site fee?**

   a. Medicare still can pay the distant site fee.
   b. Medicare will not pay the distant site fee.
   c. Medicare will pay both fees to the distant site.
   d. Medicare will reduce the distant site fee by 50%.

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LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

$7 Million Verdict: Improper Use of Balloon Device Leads to Death

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News: A woman presented to a hospital to undergo treatment for an aneurism. The treating physician, a neuroradiologist, used a balloon catheter to increase the size of the artery and support a series of coils. As a result of his inexperience with the device, the physician overinflated the balloon and caused a laceration in the patient's artery. This laceration led to a brain bleed, which was untreated and caused the patient's death.

The patient's two children initiated suit on her behalf, spurring a battle of the experts and a blame game between the neuroradiologist and the anesthesiologist. It became clear through the trial that the anesthesiologist's position was well supported by the available evidence in the medical record. After a lengthy trial and deliberation, the jury returned a $7 million verdict in favor of the estate, but only against the neuroradiologist.

Background: On May 6, 2013, a 55-year-old woman underwent a neuroendovascular coiling procedure under general anesthesia at a hospital. The patient elected to undergo the procedure to treat a right middle cerebral artery bifurcation aneurysm using an inflated balloon catheter to hold a series of metal coils in place. The procedure was performed by a neuroradiologist from her employer-radiological consulting company, with the assistance of an anesthesiologist. During the procedure, it was determined that the patient suffered a laceration to the right middle cerebral artery, resulting in a brain bleed. She died three days later.

AS A RESULT OF HIS INEXPERIENCE WITH THE DEVICE, THE PHYSICIAN OVERINFLATED THE BALLOON AND CAUSED A LACERATION IN THE PATIENT'S ARTERY.

The patient's two adult children, as administrators of their mother's estate, sued the two physicians and their practices for medical malpractice which caused their mother's wrongful death. The patient's estate alleged that her fatal injury arose either from the failure to administer the proper amount of anesthesia or the negligent use of the balloon device.

The defendants collectively disputed liability, with the physicians pointing fingers and claiming the other was directly responsible for the brain bleed. The neuroradiologist alleged that the anesthesiologist used insufficient anesthesia, which caused the patient's head to buck and jerk two to three times, with her head lifting at least six to eight inches off the table during the operation.

In response, the anesthesiologist denied the patient's head moved during the procedure. He contended that the neuroradiologist did not know how to properly use the balloon device and fabricated the movement of the decedent's head to circumvent liability. The anesthesiologist testified that the patient's head could not have moved as it was taped to the table, and evidenced this with photographs.

The neuroradiology expert testified that the patient's

death was caused by overinflation of the balloon device. The anesthesiologist's expert testified that it was scientifically implausible for the patient to have been insufficiently paralyzed from anesthesia given the conditions recorded.

The plaintiff's neuroradiology expert testified that the neuroradiologist misused the balloon catheter, overinflating the device and allowing blood to enter it. He concluded that the contention that the patient's head moved was unlikely.

The trial lasted seven days, and after six-hour deliberations, the jury found in favor of the plaintiff against the neuroradiologist and his associated consultancy. The estate was awarded approximately $7 million in damages, with each child receiving $3.37 million and the estate receiving $239,118.98 in medical expenses, along with $21,660.85 in funeral expenses, plus prejudgment interest. The award was capped at $2.05 million under applicable Virginia law. The anesthesiologist and related anesthesiology group were found not liable.

What this means to you: The operating table is not the place for experimentation or untested techniques. Of course, this limitation does not apply where informed consent is acquired. The neuroradiologist should have informed the patient of the risks associated with the balloon device and his lack of experience with the technique, as described by the anesthesiologist. When used properly, balloon catheters can enlarge narrow openings in the body, but in the hands of the inexperienced, the balloon can rupture blood vessels, as it did here.

The anesthesiologist in this case demonstrated an excellent knowledge of the procedure the patient underwent. While it is unclear whether he noted the exact amount of anesthetic administered, he did document other parts of the procedure. Perhaps noting the neuroradiologist's lack of experience with the balloon catheter, the anesthesiologist was careful to create a robust medical record by photographing the steps he took, including taping down the patient's head. Without this photographic evidence, it would be difficult to determine the cause of the patient's death and could ultimately result in liability for the unwary or the lazy. The anesthesiologist could have demonstrated even further his conformity with the medical professional standard by noting the amount of anesthetic given to the patient throughout the procedure and any reactions she may have had.

The record also is unclear as to what steps were taken in the three-day period leading up to the patient's death to alleviate her brain bleed. Patients with brain bleeds must be closely monitored, as a lack of oxygen to the brain has seriously deleterious effects. In a brain bleed situation, physicians should first focus on stabilization of the patient. While stabilization takes place, the patient may need to be placed on a ventilator to keep the oxygen saturation level high. Further, the patient's blood oxygen level and pressure in the skull should be monitored carefully.

After stabilization, the physician must address the source of the bleed itself. One option is surgery, but whether to operate depends on the size and location of the hemorrhage. Medications are available to ease brain bleed treatment. Antihypertension agents may be used to lower blood pressure and prevent the exacerbation of the hemorrhage, while acetaminophen may be used to lower fever and relieve headaches. Anticonvulsants should be used in situations involving seizures. More and more data suggest that statins, a medication typically used to lower cholesterol levels in the blood, can have neuroprotective properties, but it appears that data more conclusively support the use of statins pre-hemorrhaging than it does during or post-hemorrhaging.

While it was found that the anesthesiologist in this case was not negligent in administering anesthetics and preparing the patient for her operation, a discussion of best practices in head surgery anesthetics is worthwhile. Before administering anesthetics, it is crucial that medical professionals ask their patients whether they are currently taking any medications or are allergic to any anesthetics. Comorbidities and other preoperative assessment factors also must be assessed to avoid complications. After conducting his or her preoperative inquiries, the physician should anticipate needed equipment and specialists, then ensure their availabilities to prepare for worst-case scenarios. Finally, before the operation begins, the patient should be placed in the most ergonomic position possible to avoid pressure sores, and, in the cases of head operations, should be secured to avoid cranial damage. At this point, anesthetics can be administered.

Note that every medical facility includes a physician chief of staff and a peer group of physicians that comprise the various medical and surgical committees that oversee the medical and surgical practices within the facility. Each medical and surgical committee includes a medical director. It is the role of each committee to determine what procedures can be performed in the facility and which physicians are credentialed to perform them. Credentialing is a critical process that requires proctoring of

inexperienced physicians by those with expertise in the procedure in question. Experimental procedures undergo even further scrutiny by institutional review boards and must meet strict FDA guidelines to protect research subjects. Clearly, this physician was not or should not have been credentialed to perform the procedure. OR staff are trained and are responsible for reviewing the credentials of all surgeons performing procedures, and have the authority and responsibility to prevent the procedure if there are questions about a practitioner's ability. ■

REFERENCE

Decided on July 19, 2017, in the Virginia Circuit Court, Fairfax County; Case No. 2016-01808.

Defense Verdict in 11-Year Delay-in-Diagnosis Case

News: In 2004, an elderly man presented to a physician for a regular check-up, during which his prostate-specific antigen (PSA) levels were tested to screen him for prostate cancer. The result of the PSA test revealed unhealthy levels, suggesting cancer. Counter to the medical care facility's procedures, the physician failed to refer the patient to a urologist. The patient returned numerous times for additional check-ups unrelated to prostate cancer. The physician screened the patient for prostate cancer several times during these visits.

Eleven years after the first PSA test, the patient visited a urologist at the same medical care facility who noted his high levels from 2004 and conducted another PSA test that revealed an increase in the protein to 130, well above healthy levels. The patient filed suit alleging, inter alia, the failure to diagnose caused a reduction in his life expectancy. However, because of the patient's old age, the jury ruled for the defense because it found that an early diagnosis would not have prevented a life expectancy reduction since treatment would have been impossible.

Background: A man presented to his long-time primary care physician for a regular check-up in April 2004. The patient consented to a prostate cancer screening blood test for PSA. The PSA test returned a result of 4.5, but the patient was never informed of the results. The contemporary medical consensus is that a PSA result of 4.0 and less is a negative test result, and a result of more than 4.0 requires a biopsy to determine whether cancer is present.

In the years following the medical examination, the patient was seen at the same medical facility on numerous occasions, including for routine diabetes care, "well adult visits," minor illnesses, and elective surgeries. The patient continued to see the primary care physician for annual visits and minor illnesses.

On Sept. 16, 2009, the patient presented to the physician for a well adult visit. The physician presented the patient with information about prostate screening. The patient consented to the prostate screening, which included digital rectal exam and PSA. The digital rectal exam was charted as normal and the patient was not notified of any abnormal PSA result. No follow-up was ordered, and the patient's medical records did not reflect that a PSA was performed.

On Dec. 21, 2011, the patient presented to the physician for a "planned care visit to review medications, chronic conditions, and develop care plans as necessary." The patient received information about prostate screening, just as he did in 2009, which included both PSA and rectal exam. The patient consented to the prostate screening. The digital rectal exam was described as: "prostate soft, normal-sized, non-tender, and symmetric without nodules." The patient never was informed of any abnormal PSA result. No follow-up was ordered, and the patient's medical records do not reflect that a PSA was performed.

Four years later, the patient saw a urologist at the same medical facility, who reviewed his medical record and recognized his high PSA levels in 2004 and the lack of follow-up PSA testing. The urologist also informed the patient of the medical facility's policy that any patient with a PSA as high as 4.5 is required to be referred to a urologist. The urologist recommended a follow-up PSA test, which returned a result of 130. The patient then underwent X-rays and a prostate biopsy, which confirmed metastatic prostate cancer. The patient then quickly began cancer treatment, including chemical treatment and surgical castration, which likely caused him to have a shorter life expectancy.

The patient filed suit against the medical facility and the primary care physician, alleging that medical malpractice resulted in several types of damages. The defendants stipulated the physician was negligent in failing

to follow up on the abnormal PSA test results and that such failure caused a delay in diagnosis of prostate cancer. The defendants disputed whether that breach in the standard of care proximately caused injury to the plaintiff, as his cancer was not treatable for cure in 2004 and, once the cancer was discovered and treated, the plaintiff responded well to treatment. The case proceeded to a two-week jury trial, resulting in a verdict in favor of the defense.

What this means to you:
At first blush, this is a relatively straightforward failure-to-diagnose case, but the essence of this case is that the patient's cancer would not have been cured in 2004 if the physician had made the proper diagnosis and followed up appropriately, resulting in a defense verdict. It is still unfortunate for the patient in this case that his diligence in consenting to prostate screening was met with a marked lack of diligence by the physician. At two distinct points, the patient consented to follow-up PSA testing, but did not undergo PSA tests.

Note also that the PSA test in this case can be used to establish its own baseline. When patients are treated for prostate cancer, it is imperative that physicians take a PSA reading after treatment. The patient should return later for another PSA reading. This process permits medical professionals to determine whether PSA levels increase post-treatment, indicating a cancer recurrence. One test showing a PSA increase is inconclusive evidence of a recurrence, or "biochemical relapse." PSA tests may give false-negative or false-positive results, and a better indication of recurrence is a trend of increasing PSA levels over time. Thus, best practices for medical facilities in a prostate cancer case dictate multiple PSA tests for patients post-treatment.

The industrywide understanding within the medical community changes as a function of time. The patient in this case was castrated, a typical treatment for prostate cancer. Metastatic castration-resistant prostate cancer remains incurable despite decades of treatment improvement and evolution. This case provides an excellent study of why medical facilities must adopt policies that take change into consideration. Physicians must be encouraged to review the medical records to ensure test results and symptoms that were previously unimportant in the medical community are not alarming given current understandings. Had the physician reviewed the patient's medical record with a careful eye in the numerous occasions during which he treated the patient, he would have noted the high PSA levels. Hopefully, armed with that knowledge, he would have followed the medical care facility's procedures and referred the patient to a urologist.

In 2015, the patient was 80 years old and had a number of health comorbidities. As such, treatment of his cancer was likely dangerous, even in 2004. In fact, the defendants argued that the patient's cancer in 2004 was untreatable given his comorbidities and old age. While the jury ultimately agreed with the defense's position, the facts of this case highlight an important issue in the medical industry: treatment strategies of the elderly. When an elderly individual presents to a medical facility for specific treatment, it is critical that medical professionals establish a baseline of the patient's comorbidities. Physicians should check for commonly occurring ailments that affect elderly patients, such as arthritis, heart disease, cancer, respiratory diseases, osteoporosis, diabetes, Alzheimer's, dementia, influenza, and pneumonia. Creating a baseline allows medical professionals to see a high-level view of the patient's overall health and permits a control to which one may refer when treatments change.

Moreover, at the very least, this patient deserved a discussion with the physician about his test results and the facility policy to refer him to a urologist for further workup. Regardless of age and number of comorbidities, every patient has the right to be informed about his or her medical condition, test results, options for care, and possible consequences for refusal of care. The physician's failure to inform the patient of the possible presence of prostate cancer, a common killer of elderly men, was negligent. This patient was denied the ability to be informed about his health, make choices in his options for follow-up, and possibly extend his life expectancy.

Metastatic prostate cancer usually manifests in bone. It is a very painful condition that causes rapid deterioration in health. It is not a way anyone would choose to die. If the physician purposefully omitted telling the patient about the abnormal test result because he felt the patient was too old for treatment, then the negligence was deliberate and unconscionable. It denied the patient the right of self-determination. The defense in this case was very fortunate that the jury decided that the prior failure to follow up did not cause harm. Otherwise, if harm had been caused as a result of a deliberate decision denying the patient the right of self-determination, the patient's lawyers would have pursued other causes of action, potentially yielding punitive damages. ■

REFERENCE

Decided on May 10, 2017, in the Superior Court of Washington, King County; Case No. 2016-2-10418-5.