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INSIDE

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Patient Demand for White Caregivers Prompts Lawsuit

A healthcare center in Michigan is facing a lawsuit from six certified nursing assistants (CNAs) who say it harmed them by honoring patient demands for white-only caregivers, illustrating the difficulty of addressing these situations without running afoul of employment laws.

The CNAs are black and either currently or recently employed by Providence Healthcare and Rehabilitation Center in Zeeland, MI, which provides memory care, rehabilitation, retirement living, and assisted living to mostly senior citizens. The lawsuit filed with the U.S. District Court for the Western District of Michigan Southern Division alleges a pattern of racial discrimination over several years related to patient preferences.

Some residents asked that black employees not care for them, and those requests were honored in at least some cases, the lawsuit claims. The patient requests were even noted in the patient care plans, the complaint says.

> "TITLE VII PROHIBITS DISCRIMINATION AGAINST EMPLOYEES ON A NUMBER OF CRITERIA, AND OVER TIME THE COURTS HAVE BEEN CLEAR THAT THAT INCLUDES CUSTOMER PREFERENCES."

When the plaintiffs were assigned to care for those patients, "they would be switched with a Caucasian employee, they would be told not to care for the patient," the lawsuit says. "If they cared for the patients, they were called racist names by the patients who believed such requests were permissible because of [Providence Healthcare's] failure to properly address."

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The lawsuit claims the six CNAs filed a formal complaint with the facility administrator but that he retaliated and made working conditions worse for them, while racial harassment from patients continued. They are suing for past and future wages related to being reassigned from these patients, compensation for mental and emotional distress, and punitive damages for violation of federal labor laws.

The facility's corporate owner, Providence Life Services based in Tinley Park, IL, issued a statement saying it was not able to comment on the allegations due to the pending litigation except to say it does not modify staff assignments based on race.

Title VII Prohibits Discrimination

Local, state, and federal laws, most notably Title VII of the 1964 Civil Rights Act (CRA), prohibit employers from making any decisions about job assignments, promotions, or other terms of employment based on the person's status in a protected category. The protected categories include race, gender, national origin, disability, age, and in some jurisdictions, sexual orientation. *(For* Healthcare Risk Management*'s coverage of earlier cases involving racially discriminatory requests from patients, see story in September 2015* HRM *at: https://bit.ly/2sLCRGb.)*

These situations can be difficult for healthcare organizations trying to keep patients satisfied and avoid conflict with caregivers. Patients often ask for caregivers that make them more comfortable, and the request does not always concern race or other outright discrimination, notes **Esra Hudson**, JD, partner and chair of the labor and employment practice at the Manatt law firm in Los Angeles. Patients may ask for caregivers of one gender or another, for instance.

"Hospitals and other healthcare providers tend to try to accommodate those requests because there is a culture of accommodation generally regarding patient desires," Hudson says. "But Title VII prohibits discrimination against employees on a number of criteria, and over time the courts have been clear that that includes customer preferences."

With respect to patients, the courts have taken two different views, Hudson says. Some courts have said that accommodations for customer preferences are acceptable unless there is some sort of adverse employment effect, she says. Other courts have taken a different view, saying that the very act of accommodating the request is an

EXECUTIVE SUMMARY

Six nursing assistants are suing a healthcare facility for allegedly catering to patient demands for only white caregivers. Dealing with such requests requires adherence to clear policies.

- Healthcare facilities must adhere to Title VII employment requirements.
- Employees can be reassigned for their own benefit, but do so carefully.
- Gender requests may be accepted more easily by the courts.

adverse change to the conditions of employment.

"There's a split in the way courts have handled this. For some protected categories there is a bona fide occupational qualification exemption under Title VII, so things like gender that relate to privacy are more viable patient accommodations you can give," Hudson says. "When it comes to race there really isn't a bona fide occupational qualification you can make, so when healthcare organizations accommodate those requests, they are creating risks. Courts will find that they are violating Title VII."

Clear Policy Required

Any race-based accommodation is risky because the U.S. Equal Employment Opportunity Commission (EEOC) has made it so clear that race can never be an occupational qualification, says **Joseph P. McConnell**, JD, partner with the law firm of Morgan, Brown & Joy in Boston.

"When Title VII first came out, there were businesses that said their customers didn't want people of a certain race serving them. But on race, ethnicity, or national origin, the EEOC has never seen that as defensible," McConnell says. "If the issue is language there can be some overlap if the patient needs to communicate with someone who speaks their language, but that accommodation is not about the person's race or ethnicity."

Healthcare organizations must respond carefully when patients ask that particular employees or types of employees not provide care, says **Christopher Metzler**, PhD, chief growth officer and CEO of FHWFit, a global healthcare conglomerate in Washington, DC. There should be a uniform policy that such race-based requests are not honored, he says.

The rehab center in this case should have responded by saying, "We do not do that," Metzler says.

He suggests that the patient contract include a statement saying such discriminatory requests will not be honored under any circumstances.

> "WHEN IT COMES TO RACE THERE REALLY ISN'T A BONA FIDE OCCUPATIONAL QUALIFICATION YOU CAN MAKE, SO WHEN HEALTHCARE ORGANIZATIONS ACCOMMODATE THOSE REQUESTS, THEY ARE CREATING RISKS."

Hudson says the policy could state that the organization does not discriminate against employees on the basis of any protected category under Title VII, including race.

Monitor for Abuse

But that doesn't always end the matter.

"They then have to follow up. If they say no to the patient and let the employees treat the patient, the employer has an obligation to know what happens afterward," Metzler says. "Are the patients calling the employees racist names and being abusive against them? The healthcare employer has to monitor that because state, federal, and local law prohibit discrimination of any kind in an employment situation."

The risk manager must monitor the situation to ensure that the employees in question are not subjected to a hostile work environment, he explains.

Metzler cautions against focusing too much on the potential financial loss of losing a patient whose demands are not met. That loss must be weighed against the potential cost of an employee suing for discrimination, which will be much larger, he says.

Hudson says the overall approach to race-based requests should be to say no, but there might be exceptions. If a patient has dementia and cannot be reasoned with, for instance, it might be possible to accommodate the request if doing so results in no adverse results for the employee.

"That pattern in the courts has been against those providers who have a more general policy of accommodating patient requests even when doing so resulted in some adverse action against the employee — which is likely to happen if you try to accommodate everyone who makes this request," Hudson says. "There may be cases in which you can look at the facts and determine that accommodating the request is the least harmful solution, but that is going to be true only in rare circumstances. Even then, you are opening yourself up to Title VII violation claims by making that choice."

The courts see gender differently from race when it comes to patient requests, but accommodating those requests is not without risk.

"Courts are more willing to hear the argument for why patients might want to be cared for only by male or

female caregivers, but it's still a pretty high threshold," McConnell says.

Healthcare employers can run into trouble even when responding to these requests with the best intentions, Metzler notes. Administrators may find the patient's attitude detestable but still be reluctant to subject employees to offensive comments and emotional abuse, so it can be tempting to say "the patient is wrong, but we'll reassign you for your own protection."

That's legally risky, following the 1996 class action lawsuit by the EEOC against Mitsubishi Motor Manufacturing of America. EEOC claimed that more than 300 women at the company's Normal, IL, plant had been subject to sexual harassment starting in 1988, and that the company had denied some assignments to women ostensibly to protect them from the abuse they would face in those positions. Mitsubishi settled the case for $34 million. *(For more information on the lawsuit, visit: https://bit.ly/2HqEbTT.)*

"There used to be a philosophy that you wouldn't promote women to certain positions in this all-boys club environment, but they found that doesn't work, that it's not your obligation to be paternalistic. It's your obligation to stop the harassment," Metzler says. "But I will tell you as a business owner myself, it's a tough and hard call from a business standpoint. I don't want to put my employees in a situation where they're going to be abused, and in the case of patients I don't have any control over their behavior as I would with employees."

Metzler says it is possible to reassign caregivers to protect them from abusive patients, but only with important caveats. The reassignment must not negatively affect the employee in any way regarding pay, benefits, work schedules, or working conditions, and the employer must make clear why the employee is being reassigned.

This solution may be best when the employee has complained about abuse or disrespect from the patient, he says.

> "AS LONG AS THEY'RE NOT LOSING ANYTHING AND IT'S NOT RETALIATORY, YOU CAN EMPLOY THAT REASSIGNMENT AS A RISK MANAGEMENT TOOL."

"You can explain that you've reviewed the complaint and you take it seriously, and this is a possible solution. The employee may be happy to move to another area, but he or she might also say no and want to stay in the same unit," Metzler says. "But as long as they're not losing anything and it's not retaliatory, you can employ that reassignment as a risk management tool. You do have to be very cautious in the language you use to describe what you're doing and why."

Obligation to the Employee

The employer's obligation in such a situation is always to the employee, not the patient, McConnell says. The first step should be telling the patient that he or she is not allowed to use discriminatory or abusive behavior toward the employee, he says. He had a case recently in which a schizophrenic patient in a group home used racially abusive language to an employee.

"We determined that the group home had to take affirmative steps to stop the person from making those statements, to tell them that it was not acceptable as part of the treatment plan," he says. "The employer also explained the situation to the employee, that this behavior was a symptom of the patient's mental illness but still not acceptable. They offered to put the employee in a different position that would have no detrimental effect on his employment."

Hudson emphasizes that when an employee's assignment is changed because of a patient's request or abusive actions, the decision and the explanation to the employee must be documented carefully.

"The overall policy must be that you do not discriminate on the basis of race or other conditions under Title VII, so if there is a deviation from that policy — or what appears to be a deviation because you're protecting your employee — you need to be able to show why you came to that decision," she says. ■

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Coding Issues Carry Major Liability, Compliance Risks

Coding and reimbursement are so complex, and so vital, that healthcare organizations devote substantial resources to doing it correctly, making it easy for risk managers to assume someone else is taking care of that department while you have so much else on your plate.

However, the best strategy is to work closely with counterparts in coding and reimbursement to ensure the organization is not exposed to substantial liability from deliberate fraud or inadvertent errors.

Coding and reimbursement can create liability in many ways, and risk managers must ensure the correct safeguards are in place, says **Donna K. Thiel**, JD, a shareholder with the Baker Donelson law firm in Washington, DC.

"There are so many systems that must be in place for reimbursement, starting with the initial service provider and on through the process until the claim is submitted to the insurer, and at any point along that chain you can have a problem," Thiel says.

"It could be a surgeon who doesn't do notes on time, transposed numbers in the record, a coder who enters the wrong code for reimbursement," she adds. "As a risk manager it's really hard to anticipate where you would look, but you have to follow the path, walk a claim all the way through the system, and see where mistakes can happen."

The risk manager may not be directly responsible for ensuring coding compliance, but he or she should make sure the correct processes are in place, Thiel says. Work closely with the person in charge of reimbursement systems, offering expertise in process management and emphasizing the potential liability when procedures are not followed.

Major Prosecution Focus

Billing and coding fraud is a primary target for regulators and prosecutors now, says **Geoffrey R. Kaiser**, JD, a partner with the law firm of Rivkin Radler in Uniondale, NY.

Coding misconduct is a species of billing fraud, he notes, which is a major source of civil and criminal liability in the healthcare industry. Such misconduct may be prosecuted civilly under the False Claims Act, or under a range of criminal statutes, including healthcare fraud.

"For example, hospitals and other providers might utilize improper diagnosis codes to justify the performance of services for which there is no actual medical necessity and which are therefore non-reimbursable," he says. "Or providers may bill a procedure code for a more complex, higher-paying service than was actually performed or justified, a practice known as 'upcoding.'"

Some of the top coding risk areas for hospitals include the Two-Midnight Rule, short stay claims, inpatient psychiatric services, and inpatient rehabilitation services, Kaiser says.

The Two-Midnight Rule addresses concerns about hospital use of short inpatient and long outpatient stays, Kaiser explains, and states that inpatient payment generally is appropriate if physicians expect Medicare beneficiaries' care to last at least two midnights. Otherwise, outpatient payment is more appropriate.

Short stay claims refer to outpatient outlier payments made to a hospital when the hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment, he says.

"The purpose is to ensure access to care by having Medicare share in the financial loss incurred by the hospital in connection with individual, extraordinarily expensive cases," Kaiser says. "OIG has previously determined that high charges incurred by hospitals unrelated to cost lead to excessive inpatient outlier payments, and OIG is examining the same issue for outpatient stays."

Rehab, Psych Are Hot Topics

The Health and Human Services Office of Inspector General (OIG) is

EXECUTIVE SUMMARY

Liability issues related to coding can be significant and require the attention of the risk manager. Know and monitor the top issues of concern.

- The culture must encourage reporting concerns about fraud.
- Healthcare organizations must audit coding practices routinely.
- Consider implementing a coding fraud hotline.

examining Medicare outlier payments to hospitals providing psychiatric treatment for those with acute mental health issues, Kaiser notes. Total Medicare payments for inpatient stays resulting in outlier payments have been increasing, so OIG is examining whether hospital providers are complying with Medicare documentation, coverage, and coding requirements related to such stays.

OIG also is examining whether hospitals specializing in providing intensive therapy to inpatients recovering from illness, injury, or surgery are providing such rehab therapy to those who are not suitable candidates, Kaiser says.

The best way to mitigate risk, he says, is to implement a robust compliance program with policies and procedures tailored to these and other hospital risk areas.

"Any effective compliance program includes periodic risk assessments and auditing/monitoring to ensure compliance. Such auditing/monitoring will include random sampling of medical and billing records for review to examine coding practices," Kaiser says. "This can be performed on either an historical or prospective basis. The advantage of a prospective or prepayment review is that any errors can be corrected before claims are submitted and payment is received from payers."

Such a compliance review can then be followed by supplemental training for affected personnel as appropriate, he says.

Fraud Hotline Is a Must

Fraud reporting is a key element in any coding compliance program. Any effective compliance program will include procedures for employees to report fraud anonymously and confidentially, and will establish clear channels of communication within the organization for the reporting and receipt of information related to fraud and other compliance violations, Kaiser says.

An effective compliance program also will contain a strict prohibition against retaliation for an employee's good faith reporting of compliance violations, Kaiser says.

Thiel agrees, emphasizing the need for a culture in which employees have no fear of retaliation and feel they will be rewarded for bringing potential coding liability to the attention of superiors.

"If anyone feels something is being done incorrectly, it is critical for the organization to have a way for employees to report that to compliance easily and quickly, anonymously if they want, and without any fear of retaliation," she says. "There should not be any hospital in existence without that mechanism in place."

"Any hospital that doesn't is very much at risk, vulnerable to accusations that they did not do everything possible to encourage reporting and they were negligent for that reason," she adds.

Kaiser notes that Anti-Kickback Statute and Stark Law violations are a focus of law enforcement, with agencies interested in hospital-physician relationships and unlawful payments to, and financial relationships with, referral sources.

Five Key Elements for Compliance

Although a hospital's revenue cycle management team ultimately is responsible for billing compliance, which includes coding, billing, and collections, the risk manager should consult with them concerning potential liability and compliance efforts, says **Ben Wright**, senior solutions architect in the Fraud and Security Intelligence Division at SAS, a company based in Cary, NC, that provides software and compliance consulting.

Wright says the risk manager should look for these key elements in billing compliance:

1. There must be a current coding compliance policy. The integrity of coded data and the ability to turn it into functional information requires all users to consistently apply the same official coding rules, conventions, guidelines, and definitions. Put more plainly, Wright says, this should be a policy that all staff will only use the codes that are clearly and consistently supported by authenticated clinical documentation in accordance with code set rules and guidelines.

2. The policy should be segmented. It should be laid out by care setting, department, and medical specialty (such as inpatient, outpatient, ambulatory surgery, observation, emergency) and segmented into public plan requirements and private (commercial) plan requirements.

3. The policy must be reviewed and updated at least annually. The review should take into consideration coding rule changes, additions, and deletions, which generally occur annually.

4. The plan needs to consider the effects of newer reporting technology. This may include electronic health record software that makes it possible to complete check boxes that formerly were on paper or nondigital media and will now require an audit trail. Who actually

checked the box? Was it a template? Was it copied from another record? All of those questions and more should be determined in an audit trail.

5. There should be a plan for continuous monitoring and analytical evaluation. This will help detect, prevent, and investigate coding anomalies and/or practices that maximize revenue at the expense of compliance.

Follow OIG Work Plan

The risk manager should follow the OIG work plan, says **Arlene Baril**, senior director of facility coding and audit services at Change Healthcare, a company based in Nashville, TN, that assists healthcare organizations with transitioning to value-based care. The OIG work plan used to be published on an annual basis, but now is updated monthly.

The work plan denotes OIG's areas of interest, including billing compliance issues that are on the radar of regulators.

(The work plan is available online at: https://bit.ly/2rzhtUM.)

Also stay abreast of CMS Program Transmittals to determine coding changes, changes in coding/billing rules, updated or deleted regulations and similar issues, and make sure coding professionals are doing the same, she says.

(The transmittals are available online at: https://go.cms.gov/2IhciiE.)

Be sure to review all coding changes for ICD-10-CM and ICD-10-PCS, which are updated annually in the *Federal Register* in October, Baril advises. *(They are available online at: https://go.cms.gov/2vHIhok.)* Also stay on top of Outpatient Prospective Payment System coding changes, which are updated on a quarterly basis in the *Federal Register* in January, April, July, and October.

Baril also suggests reviewing your organization's Program for Evaluating Payment Patterns Electronic Report, also known as PEPPER. This report shows how one's facility fares with other facilities in the nation on billing compliance. *(The quarterly reports are available online at: https://bit.ly/2HLLhCN.)*

Determine who your Recovery Audit Contractor (RAC) is and subscribe to their updates to keep abreast of all CMS compliance topics, she advises.

Best Practice Coding Policies

Baril recommends establishing the following best practice coding policies and procedures:

1. Standards of Ethical Coding from the American Health Information Management Association (AHIMA);
2. AHIMA's Ethical Standards for Clinical Documentation Improvement Specialists;
3. Physician Query Process;
4. HIM Coder Training and Education;
5. Home Office Compliance Audits;
6. Internal Coder Monitoring;
7. Internal Coding Quality Assurance Program;
8. Chart Elements required for Final Coding (by Chart Type);
9. New Hire Training/ Orientation;
10 Contract Coding Arrangements;
11. External Coding Consultants;
12. External Clinical Documentation Consultants;
13. External Coding Compliance Audits;
14. Coding Continuing Education Requirements Policy.

Each coder should be audited internally on a quarterly basis, Baril says.

"Findings and education should be timely to correct any abnormal trends. Follow-up audits should provide another review of previous findings to determine if the issue has been resolved," she says. "It is also recommended to have an external audit on a minimum annual basis. Many facilities opt to have external audits done on a quarterly basis, especially after the coding changes go into effect."

Review samples can be determined on a per-coder basis, and they might also target particular MS-DRGs/APCs, RAC-approved issues, PEPPER report items, OIG targets from the work plan, or a combination of all items, she says.

"Every employee should have annual education on the hospital's compliance program. They should have copies of all related compliance policies and procedures," she says. "The employees should be made aware of the coding compliance hotline if they decide to remain anonymous. If they decide to come forward, they must be assured of the non-retaliation policy in effect." ■

SOURCES

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Social Media and Young Nurses Could Be Bad Combination

Risk managers should make a point of cautioning young nurses about the risk of social media, suggests **Georgia Reiner**, risk specialist for the Nurses Service Organization in the Healthcare Division of Aon Affinity insurance services.

Nurses new to the field should be reminded about the risk to their own careers from careless or unwise posts on social media, which also will help protect the hospital or health system from associated liability, Reiner says.

Common problems with social media involve unprofessional conduct, such as posting images or remarks about excessive alcohol use or illegal drugs, profanity, sexually explicit material, racial slurs, threatening or harassing comments, and negative comments about co-workers or patients.

Another area of concern is inappropriate posting of information about patients, Reiner notes. This could include photos of patients or any information that might be used to identify a patient.

Nurses are likely to respond to any warning about the danger of social media posts that do not involve the workplace or patients by saying their work and private lives are separate, that they should not be punished for what they do on their own time. But real life doesn't play out that way, Reiner says, and nurses need to know that.

"Courts have supported disciplinary action taken against nurses for what they do in their personal lives, including posting on social media," Reiner says. "The California Supreme Court upheld a ruling that allowed the state nursing board to discipline a nurse who had been caught driving drunk, even though the arrest had nothing to with her job. The result is any nurse in the state of California who is arrested for DUI can have her nursing license suspended by the board of nursing."

Younger nurses are particularly vulnerable to social media faux pas because they grew up using the outlets and consider posting information about themselves second nature, Reiner says. They pose a higher risk for incidents that could not only damage their careers, but also turn into lawsuits against their employers.

"As these younger nurses are brought into the profession, we're going to see more and more professionals who are using social media and not exercising appropriate caution," she says. "More and more healthcare organizations are implementing social media policies, but there needs to be training to back up those policies and enforce them."

Reiner recalls a case in which a nursing assistant went into labor at work and her co-workers posted video photos online, mocking the woman in labor. Several employees were terminated and investigated by the nursing board.

Reiner suggests including the following fundamentals in a social media policy and reinforcing them with education targeted specifically to younger nurses:

- Always maintain patient confidentiality. Never post patient photos or information, or anything that might be used to identify a patient.
- Don't refer to patients in a disparaging manner, even if the patient is not identified. It does not reflect well on the nurse or the employer. It is wise to simply avoid posting about patients.
- Do not post inappropriate comments about colleagues or your employer.
- Do not post medical advice, or anything that could be construed as medical advice, even to friends and family.

The increased use of social media makes it more important for nurses to carry their own malpractice insurance, Reiner says, because there will be more claims related to online posts.

"If the nurse were to be involved in some kind of civil litigation, the employer's nursing policy may not cover them if they were found to be acting outside the scope of their employment," she says. "If they violate the employer's social media policy, the nurse would be left on their own to defend the civil claim." ■

EXECUTIVE SUMMARY

Young nurses are at a higher risk of misusing social media. Their online actions can lead to liability for themselves and their employers.

- Educate nurses about proper online behavior.
- Remind them that off-duty behavior can threaten their careers.
- Nurses may have to pay for their own defense in civil litigation.

SOURCE

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Overdose Prevention Act Would Ease the Way for Sharing of Substance Use Disorder Info

A bill currently making its way through Congress could address current problems with how information on mental health and substance use disorders (SUDs) is shared among healthcare providers.

The proposed law still would place tight restrictions on the data and prohibit discriminations against patients with these conditions, says **Gerald E. (Jud) DeLoss**, JD, an attorney and officer at Greensfelder, Hemker & Gale in Chicago.

DeLoss focuses his law practice on mental health and SUD. He testified about the bill as the subject matter legal expert before the U.S. House Energy and Commerce Health Subcommittee. H.R. 5795 would allow the disclosure of patient information related to SUD with healthcare providers, health plans, and healthcare clearinghouses for treatment, payment, and healthcare operations in accordance with HIPAA. *(The bill is available online at: https://bit.ly/2Jh9bHZ.)*

H.R. 5795 is designed to allow sharing of information about SUD and other treatment programs covered by HIPAA, DeLoss says.

"The ability for healthcare providers to see a patient's entire medical record is critical when opioids are prescribed or when contraindicated drugs could cause serious injury or death to a patient," DeLoss says.

Exception to Consent-driven Process

The bill would modify 2 CFR Part 2, a federal law governing confidentiality. The law imposes stringent protections on disclosing any information identifying a patient as having an SUD. The law restricts the disclosure of this information even in situations in which many would argue it is to the patient's benefit.

"This bill would create an exception to what is usually a consent-driven process," DeLoss says. "Each and every time in the past, the disclosure of this information has required consent, so this bill would create an exception similar to HIPAA, which says no consent or authorization is required to share health information for treatment, payment, or healthcare operations."

The bill also would eliminate the need to obtain consent each time the disclosed information is shared with another healthcare organization.

However, the exception specified in the bill is very narrow, DeLoss says.

"It's still a matter of segmenting the data, flagging the data, and making sure it is not shared with anyone except those narrowly defined parties," he says. "It's not opening it up and fully aligning with HIPAA, which is the goal of many who think we should break down the silos and the walls separating healthcare systems to allow for fully integrated care."

The bill imposes stiff penalties, including criminal prosecution, for improper disclosure of SUD information. There also is a strict prohibition against using the information in any civil or criminal procedure, or any law enforcement efforts.

SUD patients also would be protected from discrimination by healthcare professionals with access to the information, as well as non-healthcare-related protections related to housing, employment, and other issues.

"There are some broad anti-discrimination protections that will be of great interest, and possibly concern, to the medical field because this would apply when they are admitting a patient, for instance. They could not discriminate based on the patient, based on this SUD-related condition," DeLoss says. "There will need to be education for staff on how to comply with these restrictions and processes for patients who feel they are the subject of discrimination." ■

SOURCE

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EXECUTIVE SUMMARY

A bill in Congress would allow more sharing of information about substance use disorders. It is intended to address some current restrictions that can interfere with care.

- The new law would incorporate some HIPAA elements.
- There would still be tight restrictions on data sharing.
- Misuse of substance abuse information could be prosecuted criminally.

Tips for Maximizing Workers' Compensation Strategies

The healthcare industry is improving how it handles workers' compensation cases and the related liability, but many organizations could improve, says **William Brian London**, JD, an attorney with the law firm of Fisher Phillips in New Orleans.

He handles workers' comp cases in healthcare and other industries, and offers these best practices:

• Workers' compensation management strategies must be tailored to your own organization's particular needs rather than trying to adopt a one-size-fits-all approach.

"Particularly in the healthcare industry, it is important for employers to tailor their safety response and incident response programs to their organization," London says. "Each workplace is a little different, and the workers' comp program will have to be tailored to what your employees need."

• Healthcare organizations also must make sure workers' comp incidents are reported as quickly as possible and documented thoroughly, he says. The longer the delay between the accident and the time it is reported, the more expensive the claim becomes, London says.

"You run into all kinds of problems if it is not reported right away. There can be medical disputes about the injury and it's an evidentiary problem because evidence gets less reliable over time," he says.

• Clearly define roles before an injury occurs, so people know how to respond. "Everyone needs to know from the start what their jobs are. Who is taking the employee to receive the appropriate medical care? That person probably should be someone different from the person responsible for documenting and investigating the accident," he says. "You want both of those things to happen right away, so you can't delegate both to the same person."

London says he has seen healthcare organizations with response policies as simple as "Contact Human Resources after an accident." Such simple approaches lead to improvisation after an injury or overlooking important tasks, like documenting the circumstances of the accident, until it is too late, he says.

• Safety training should include information on how to respond after a workplace injury, including who to report to and what steps will follow.

"Mandatory safety training and education on the workers' comp process that follows sends the signal to employees that these are things that really matter to the company," he says. "It can reinforce the everyday practices that can help avoid these injuries in the first place."

• Once an employee is injured and off the job, make sure the workers' comp process includes frequent contact with the employee during the recovery process. It is easy for an injured employee to lose touch with co-workers and feel no longer a part of the team — which is bad for the recovery process, London notes. Isolation also can fuel attempts to maximize workers' comp benefits.

"Have someone call regularly to check in, see how they're doing, remind them that they are still a valued part of your team, and you want them back on the job as soon as possible," he says. "That kind of contact can have a powerful effect."

• Remember that the "experience mod" factored into insurance rates can significantly affect workers' comp premiums, so intervention by risk managers can affect the bottom line.

"If you aren't taking this seriously, you're losing out on the best available rates and your competitors are getting an edge," he says. "I think there has been more attention to safety and workers' comp in the healthcare industry than there has been in the past, but there is still room for improvement at a lot of organizations." ■

EXECUTIVE SUMMARY

Follow best practices to minimize potential liability from workers' compensation cases.

- Tailor your strategies to your organization.
- Assign clear roles following accidents.
- Stay in touch with recovering employees.

SOURCE

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Emergency Preparedness Guide Released

The insurer Liberty Mutual has released a whitepaper intended to help healthcare organizations better prepare for and respond to disasters.

"Emergency Preparedness in Healthcare: Learning from the Past to Improve the Future" encourages a more holistic approach to hospital disaster planning and recovery. It reviews three critical, but largely unaddressed, areas of concern in hospital emergency preparedness: credentialing difficulties, Medicare/Medicaid requirements, and emerging infrastructure issues.

"Hospitals' experience with last year's severe weather shows the industry must think beyond standard emergency plans if they are to sustain a community during a tragic event," Jeff Duncan, chief underwriting officer with Liberty Mutual, said in a statement accompanying the release of the paper.

The whitepaper addresses these key disaster preparedness best practices:

- continuously developing, testing, and refining a proactive disaster preparedness and recovery plan;
- proactively developing mutual aid agreements with other area facilities and vendors to expedite credentialing medical professionals, supplies, equipment, etc., when they are most needed;
- understanding how potential disasters might affect the hospital's structure, key equipment, supplies, inpatient services, and outpatients receiving critical care;
- determining how long the facility can operate self-sufficiently during a local catastrophe.

The whitepaper also reviews three issues highlighted by recent severe weather: credentialing, Medicare/Medicaid requirements, and emergency infrastructure challenges. Credentialing must be addressed before emergencies cause a surge of patients for hospitals, which then creates a need for additional qualified medical staff from outside the impacted area.

Hospitals must comply with the Centers for Medicare & Medicaid Services' emergency preparedness requirements, the report notes, which will help ensure coordination and communication between treatment centers serving Medicare and/or Medicaid patients affected by local emergencies.

The report notes that losing key services such as electricity can close the entire facility at a time when it is needed most, and recent severe storms show the importance of making sure generators are located in areas where they will not flood.

The whitepaper is available online at: https://bit.ly/2sCl7Nb. ■

$114 Million Penalty in Medicare Fraud Case by Whistleblowers

A federal judge in South Carolina imposed civil damages and penalties totaling more than $114 million on the former CEO of a medical testing lab and two owners of the lab's marketing partner for violations of the False Claims Act. The case was brought by whistleblowers.

The defendants were found guilty of civil fraud against Medicare and other federally funded healthcare programs, the result of three separate *qui tam* cases brought and litigated together.

Tonya Mallory, former CEO of Health Diagnostic Laboratory (HDL) in Richmond, VA, and Floyd Calhoun Dent III and Robert Bradford Johnson, owners of BlueWave Healthcare Consultants, an Alabama marketing company, must pay more than $111 million in treble damages and penalties for fraud relating to HDL's arrangement with BlueWave to market HDL blood tests in part by offering illegal kickbacks to physicians who ordered the tests.

Prosecutors said the alleged scheme involved paying doctors $20 processing and handling fees for ordering the unnecessary tests. HDL submitted 35,074 false claims to the government.

BlueWave owners Dent and Johnson were additionally found liable in a related kickback plan, which prosecutors said provided a $10 processing and handling fee to physicians to encourage them to order unnecessary tests at another specialty blood lab, California-based Singulex, Inc.

That arrangement was responsible for another 3,813 false claims to federally insured healthcare programs, costing the government $467,935. Dent and Johnson were penalized more than $3 million for that part of the plan.

More information is available at: https://bit.ly/2EqqGpL. ■

HEALTHCARE RISK MANAGEMENT™

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CE QUESTIONS

1. **According to Arlene Baril, senior director of facility coding and audit services at Change Healthcare, at least how often should a healthcare organization conduct external audits for coding compliance?**

   a. Every five years
   b. Every other year
   c. Annually
   d. Monthly

2. **What does Donna K. Thiel, JD, shareholder with Baker Donelson, suggest regarding a coding fraud hotline or similar method for reporting concerns?**

   a. Every healthcare organization should establish one.
   b. They are ineffective and unnecessary for any organization.
   c. They are necessary only if there is a history of coding fraud.
   d. They usually produce only false alarms.

3. **Regarding patient requests, what should an organization's overall policy be regarding racial discrimination under Title VII of the 1964 Civil Rights Act?**

   a. The overall policy must be that you do not discriminate on the basis of race or other conditions under Title VII.
   b. Requests for caregivers of a certain race will be accommodated whenever possible.
   c. Requests for caregivers of a certain race will be addressed by the nursing union.
   d. The overall policy can be flexible regarding Title VII, as some racially oriented requests will be reasonable.

4. **What does Georgia Reiner, risk specialist for Aon Affinity insurance services, say regarding social media and litigation?**

   a. There will be more lawsuits as the use of social media among young nurses increases.
   b. There will be fewer lawsuits as the use of social media among young nurses increases.
   c. The use of social media is decreasing rapidly, but the number of related lawsuits is steady.
   d. The use of social media is decreasing rapidly, and so is the number of related lawsuits.

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

Negligent Post-fall Treatment of Snowboard Coach Leads to $6.3 Million Verdict

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News: In early 2013, a snowboarding coach fell while snowboarding, suffering serious injuries to his legs. He was transported to a medical facility and developed acute compartment syndrome. Physicians performed a fasciotomy, but the patient already suffered irreversible damage to his legs. The patient remained in the medical facility for more than a month and required ongoing medical attention after discharge.

The patient and his wife sued the medical facility and several medical professionals, who were dismissed prior to the trial. The jury verdict in favor of the plaintiffs totaled more than $6 million, covering loss of earnings, loss of consortium, and other damages.

Background: In March 2013, a professional snowboard coach fell and injured his legs while snowboarding in Colorado with his team. He was taken to a nearby medical center, where he later underwent surgery on his left tibia. After the surgery, the patient lost the ability to move the toes on his left foot and exhibited sensation problems with nerves in his left leg. The nursing staff also noted multiple issues with his foot and leg each day for several days thereafter.

PHYSICIANS PERFORMED A FASCIOTOMY, BUT THE PATIENT ALREADY SUFFERED IRREVERSIBLE DAMAGE TO HIS LEGS.

The patient developed compartment syndrome in his left leg that persisted for several days. On March 10, nursing staff noted that the patient did not report tactile stimulation on sensation assessment. The patient underwent a duplex ultrasound later that same morning.

On March 11, the medical staff noted the patient experienced continued redness and swelling, uncontrolled pain, increased heat, and no strength to his left lower extremity. That evening, a surgeon performed a fasciotomy to alleviate pressure in the patient's extremity. Multiple follow-up procedures were conducted in the days following. The patient remained at the medical center until his discharge on April 15, but required ongoing follow-up medical oversight and care.

The patient filed suit against the medical center and multiple medical professionals; however, the individual professionals were dismissed prior to trial. The complaint alleged that the facility was responsible for the negligent acts and omissions of its employees, including failure to properly and timely consult with appropriate medical professionals regarding the care and treatment of the patient; failure to ensure that he received timely and appropriate evaluation of his condition; and failure to use the chain-of-command policy to ensure that he received care and treatment for his emergent condition.

During trial, the patient's attorney argued that compartment syndrome is an urgent condition that must be fully addressed within 12 hours to increase the likelihood that the nerves and muscles within the affected compartment of the body will survive unharmed. In this case, the facility did not treat the patient's compartment syndrome for several days.

The jury found for the patient and awarded him $418,000 for past medical care, $190,000 for lost earnings, $48,000 for other economic losses, and $500,000 for pain, suffering, physical impairment, and loss of quality of life. He also was awarded $937,000 for future medical care, $1.14 million for future lost earnings, $1.1 million for other economic losses, and $1.5 million for pain and suffering. The patient's wife was awarded $50,000 for loss of consortium, affection, comfort, and companionship, and $450,000 for future noneconomic losses.

What this means to you: Compartment syndrome is a condition in which pressure continues to build up in a patient's muscles. This pressure may decrease blood flow, resulting in oxygen and nourishment deprivation to limbs. There are two types of compartment syndrome: acute and chronic. Chronic compartment syndrome, also called exertional compartment syndrome, is a condition often caused by athletic exertion and often does not constitute a medical emergency. Acute compartment syndrome, on the other hand, is a medical emergency.

Without swift treatment, acute compartment syndrome can cause irreversible damage to a patient's muscles. This case demonstrates the harm that may result from a medical provider's failure to promptly diagnose and provide swift treatment of an emergent condition. When a medical provider does not act within the standard of care in providing such treatment, damages to the patient — and any resulting jury verdict — escalate significantly.

Compartments are the group of muscles, nerves, and blood vessels in limbs that are covered by a sheet of tissue called fascia, which is tasked with holding the compartments in place. As a result, the fascia does not easily stretch when fluid enters the compartment, resulting in increased pressure in the compartment. This increased intracompartmental pressure in turn puts pressure on surrounding blood vessels, cutting off blood to nerve cells and muscles.

This lack of blood flow is the main concern with compartment syndrome. In acute compartment syndrome, if the compartmental pressure is not relieved quickly, tissue death will occur. But in chronic compartment syndrome, tissue death typically is not a concern.

Acute compartment syndrome is characterized by pain that exceeds what would be expected from the injury itself, especially when the muscle or muscles within the compartment have been stretched. Additional symptoms may include tingling or burning sensations in the skin, tightness or fullness of the muscle, or numbness or paralysis in the late stages of the condition.

Acute compartment syndrome is diagnosable with measurement of the compartment. Exertional compartment syndrome is characterized by pain or cramping during exercise which subsides when the activity stops. Exertional compartment syndrome is seen more frequently in patients' legs and symptoms may also include numbness, difficulty moving the foot, and visible muscle bulging. It must be diagnosed indirectly by ruling out other possible causes of pain and cramping, such as tendonitis and stress fractures.

The treatment of acute and exertional compartment syndrome differs in that there are no nonsurgical means of relieving acute compartment syndrome. Acute compartment syndrome is treated by making an incision in the fascia covering the impacted compartment — a procedure called a fasciotomy, the procedure used in this case.

Postoperative compartment syndrome is a dangerous side effect of orthopedic surgery on limbs due to the body's response to the assault on the limb from the initial injury as well as the manipulation of bone, muscle, tendons, ligaments, and fascia within the surgical site. Tissues swell, blood and lymphatic fluids rush to the area, and swelling builds continually unless steps are taken to reduce these effects. Elevation, ice, pain control, rest, anti-inflammatory medications, and intense assessments of the area by medical staff are critical.

The patient in this case showed warning signs of impending compartment syndrome for several days until the pain of oxygen-deprived tissues was too much for him to tolerate. Loss of sensation, decreased movement, pain, redness, and swelling are classic signs of trouble.

Another lesson to be learned from this case is that multiple care providers could have prevented the unfortunate outcome. A system of checks and balances or minor overlap whereby both physicians and staff are trained and capable of reporting and recognizing dangerous conditions may reduce injuries — and potential malpractice.

In this case, the staff identified the patient's ailments specifically as they related to his affected limb, yet prompt action was not taken. The nursing staff diligently performed assessments of the affected limb, but either failed to notify attending physicians and surgeons or, if notified and physicians and surgeons failed to act, did not use the chain of command and escalate concerns to charge nurses, nursing supervisors, unit managers and directors, nursing

leadership, medical staff office personnel, the chief of staff, and so on.

Additionally, the surgeon should have been rounding daily on the patient and performing his or her own assessment of the limb. It is often difficult for busy physicians who are required to round daily on hospitalized patients to actually enter the patient's room and spend time on a thorough assessment; however, to do less than that is a disservice to the patient and puts the physician at risk of a malpractice action if the failure to assess is inconsistent with the applicable standard of care. Had the surgeon in this case assessed the patient's limb more frequently, the outcome for all involved would have probably been far less disastrous and litigious. ■

REFERENCE

Decided on April 24, 2018, in the U.S. District Court for the District of Colorado; case number 1:15-cv-00460.

$16 Million Verdict for Errors Leading to Amputations of Thumb and Toes

News: In 2008, a young woman diagnosed with Sjögren's syndrome began feeling ill and saw a physician. After the visit, the patient's parents convinced her to seek additional medical care, and she presented to a hospital. The physician who examined her quickly determined that she was suffering from vasculitis. Because of an overflow of patients, the woman was transferred to the cardiac care unit rather than the intensive care unit.

At the cardiac care unit, the patient was given steroids but was never properly treated for vasculitis. Multiple tests and symptoms clearly indicated she suffered from vasculitis, but the treating rheumatologist did not treat her with the necessary medication. She was transferred to a different hospital and received treatment; however, because of the delay, nine of the woman's toes and one of her fingers had to be amputated.

Background: A 25-year-old woman was diagnosed with Sjögren's syndrome, a form of lupus, in 2008 and began taking medication to control the condition. In November 2008, the woman began feeling ill and saw a doctor. She then went home, where her parents urged her to seek medical care.

The woman was admitted on Nov. 21, 2008, to a hospital, where the physician wrote an order to admit her to the ICU for a diagnosis of vasculitis, an inflammation of the blood vessels that is treated with steroids and a drug called Cytoxan.

Despite the physician's order, the patient was sent to the cardiac care unit because the ICU was full. The patient remained in the cardiac care unit for six days, but beds opened in the ICU during that time. The patient was given steroids but the treating rheumatologist failed to diagnose her with vasculitis, disregarding symptoms of the disease and biopsy results reported as "small and medium vessel necrotizing vasculitis," according to the complaint. The nursing staff noted the patient had a bilateral foot drop on Nov. 25 and abnormal neurological assessments of her lower extremities.

The patient was transferred to a different hospital's ICU on Nov. 28, where she was given Cytoxan two days later and showed immediate improvement. However, her toes and fingers were gangrenous; nine of her toes and her right thumb required amputation.

The patient filed suit against the first hospital and the rheumatologist for negligent treatment of her vasculitis, including failure to administer Cytoxan. The complaint alleged that the hospital's nursing staff failed to report abnormal neurological assessments of the patient's extremities. The complaint also claimed that the patient's symptoms clearly indicated vasculitis.

The patient specifically alleged that the rheumatologist breached medical duties by failing to diagnose and treat her for necrotizing vasculitis in a timely manner after her admission to the hospital; failing to appreciate her bilateral foot drop caused by vasculitis on Nov. 25; failing to administer Cytoxan for the treatment of necrotizing vasculitis; failing to conclude that she had no contraindications to the administration of Cytoxan; failing to communicate with other physicians regarding the skin biopsies and other diagnosing criteria that indicated vasculitis; failing to transfer her to another institution that would have treated her in a timely manner; and failing to appropriately diagnose her medical condition.

The amputations forced the patient to cancel her plans to pursue a career in the performing arts and instead pursue a master's degree in fine arts management. She now handles marketing at a performing

arts center. The patient's attorney argued that the biopsies were superfluous and that other criteria clearly indicated the patient's medical condition.

After trial, a jury cleared the hospital of liability, but found the rheumatologist liable for $15.92 million: $5 million for medical expenses, $1 million for lost earnings, and $10 million for pain and suffering.

What this means to you: These circumstances reveal how diagnostic and treatment errors can result in significant injuries to patients and significant medical malpractice verdicts. While multiple physicians involved in this case recognized the patient's vasculitis, the rheumatologist failed to do so and failed to provide the necessary medication.

Vasculitis is the inflammation of one's blood vessels that causes blood vessel walls to thicken, weaken, narrow, and/or scar. These changes restrict blood flow, which can lead to organ and tissue damage. There are many different types of vasculitis, such as Behcet's disease, Buerger's disease, central nervous system vasculitis, cryoglobulinemia, eosinophilic granulomatosis with polyangiitis, and giant cell arteritis.

Vasculitis is more commonly seen in women over the age of 40, and some types may improve without any medical intervention. Other types require medications to control inflammation and to prevent flare-ups. Once vasculitis is diagnosed, treatment primarily focuses on controlling inflammation using medications and treating the underlying disease causing the vasculitis. Treatment thus commonly involves two phases: stopping inflammation and preventing relapse. Both phases involve the use of prescription drugs.

Symptoms of vasculitis vary greatly, but often are related to a decrease in blood flow throughout the body. Some more general symptoms include fever, headache, fatigue, weight loss, general aches and pains, night sweats, rash, and nerve problems; i.e., numbness or weakness. Given the different types of vasculitis, it is critical to diagnose and treat not only the vasculitis, but also the underlying issue or disease causing the vasculitis.

For example, Behcet's disease causes inflammation of arteries and veins with symptoms including mouth and genital ulcers, eye inflammation, and skin lesions that resemble acne. Giant cell arteritis similarly involves inflammation of arteries in the patient's head, often the temples; it may cause symptoms such as headaches, scalp tenderness, jaw pain, blurred or double vision, and blindness. Medical care providers must be aware of this variety and the importance of correctly diagnosing the vasculitis and underlying disease.

The practice of medicine is an art as well as a science. Physicians may not always agree on specific diagnoses, and making the wrong diagnosis is not automatically negligent, but if the physician fails to follow the standard of care and perform in the manner of a reasonably careful physician in the same or similar circumstances, then there may be negligence. Once a diagnosis is made, physicians must consider the patient's response to treatment. If improvement is not seen within the expected time frame, then the physician must consider whether the original diagnosis was incorrect or incomplete, and further investigation and consultation is warranted.

Even if the initial incorrect diagnosis was not negligent, the failure to re-evaluate may be negligent. Consulting with other physicians, particularly specialists for complex matters or when symptoms may result in varying diagnoses, may greatly assist care providers with ensuring that their patients receive the correct and necessary treatment.

One of the missteps in this case was the rheumatologist's failure to communicate with other physicians regarding the patient's underlying symptoms. Open communication with colleagues should be encouraged at medical facilities and hospitals to foster a collaborative atmosphere and ensure the best care for patients.

Furthermore, such collaboration that results in multiple medical opinions and chances for review may later protect a physician in a lawsuit alleging medical malpractice, as reasonable physicians may reach different diagnoses given the same or similar circumstances. A care provider who objectively evaluates multiple potential diagnoses or treatments is more likely to be considered "reasonable" under the circumstances of a close call when compared to a provider who disregards other opinions.

Finally, autoimmune diseases such as Sjögren's syndrome are complex and require the expertise of those specialties such as rheumatology. However, even within the specialty, different physicians can make different diagnoses. In this case, when the patient's condition continued to worsen, the rheumatologist had the responsibility to re-evaluate the diagnosis and the treatment plan prescribed for it. Continuing treatment without considering why it was proving ineffective and why the patient was suffering increased damage resulted in a negligence and malpractice verdict. ■

REFERENCE

Decided on Oct. 31, 2017, in the Seventeenth Judicial Circuit Court of Florida; case number 11002290.