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THE NATION'S ESSENTIAL ALERT FOR HEALTH CARE COMPLIANCE OFFICERS

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Credentialing looms as major concern for OIG, DOJ

Inadequate screening of physicians and other entities can create a host of legal problems

First, a national study on the credentialing practices of hospitals surfaced on the Health and Human Services' (HHS) Office of Inspector General's (OIG) Work Plan in the form of a national study. More recently, it surfaced on the laundry list of major concerns of Assistant U.S. Attorney **James Sheehan**, chief of the civil division in Philadelphia. Those are two good reasons compliance officers should make this a top priority.

Sheehan underlines his caution with the case of a Philadelphia hospital that billed federal government health care programs for the services of a psychiatrist who, it turned out, was not even licensed in the state. The end result was a settlement with the U.S. Department of Justice.

Former Inspector General **Richard Kusserow** says there are several reasons hospitals must screen physicians, vendors, and other appropriate parties with whom they do business. The first is that as a condition of participation in the Medicare program, hospitals are responsible for making sure physicians are properly credentialed and have not had their license revoked or been excluded from the program.

The OIG has stated that, to submit a claim to Medicare or Medicaid, hospitals must ensure that person has not been excluded, says Kusserow,

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E-health not immune from existing regulations

While the regulatory landscape of e-health is only just beginning to take shape, hospitals and other health care entities are running a serious risk if they believe regulations capable of being applied in this area have not yet been created. In fact, many aspects of e-health are more than adequately addressed within the existing regulatory framework, experts warn.

"The myriad legal and regulatory requirements applicable to the face-to-face delivery of health care also apply to the virtual delivery of health care and related services through the Internet," warns health care attorney **Bernadette Broccolo**

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Nursing home abuse comes under government spotlight

Nursing homes and hospitals with long-term care facilities can help protect themselves against charges of patient abuse by establishing protocols to address this thorny but increasingly high-profile problem. Now would be a good time for compliance officers to check protocols as the government zeroes in on this issue.

The General Accounting Office (GAO) told the Senate Special Committee on Aging March 4 that 30% of the nation's 17,000 nursing homes have been cited for deficiencies involving actual harm to residents or placing them at risk of death or serious injury in recent years. The actual extent of the problem is probably even worse, it added, but no one really knows how much worse.

According to the GAO, it is a difficult problem to quantify for several reasons. First, states differ in what they consider abuse; some states do not count incidents that other states or the Centers for

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Credentialing concerns

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president of Strategic Management Associates in Alexandria, VA. "That also means that if you include in your cost report people who have been excluded, the cost report comes into question," he adds.

"You have a lot of risk there," warns Kusserow. In the first instance, providers are risking their qualification as a Medicare provider. In the second case, they can suffer sanctions from the OIG, including exclusion. "Needless to say, if you submitted 1,000 bills and part of that bill included an excluded party, those bills would be called into question," asserts Kusserow. "That could add up to a lot of money."

The third area amounts to a risk-management issue, says Kusserow. He paints the following scenario: A nurse is stripped of her credential for stealing narcotics and later has the credential restored. A hospital hires her without knowing her sanction history and has her dispensing Category III drugs. "If she did the same thing and a patient is harmed, the liability would be horrendous," says Kusserow.

The biggest penalty on hospitals in a case like this often is bad publicity and private liability, he adds. "In some respects, the larger penalty is not the government action but private litigation and tort liability," says Kusserow. "That's why it is a risk-management issue first and foremost."

"Credentialing is not a new requirement," says **Harry Shulman**, a health care attorney with Davis Wright Tremain in San Francisco.

He says failure to meet those responsibilities can lead to liability in tort litigation, which is not the same thing as being responsible for a physician's negligence.

"It is a separate cause of action against the hospital for negligent credentialing."

According to Shulman, the logic of that line of case law has been extended by the courts not only to hospitals but also to other types of entities that are responsible for negligent credentialing.

In order to cover all the necessary bases, Kusserow says hospitals must utilize the OIG's National Practitioner Databank.

In addition, the OIG has published the list of excluded individuals and entities on its web site. He says a third area that should be examined is the General Services Administration (GSA) debarment list, which covers all federal programs. "If you have been debarred from all federal programs, that certainly includes hospitals," he warns.

According to Kusserow, if providers rely solely on the OIG's web site, they will be getting only one piece of the pie. While the OIG cannot mandate that hospitals check the GSA site, it still could prosecute them if they employed a physician who had been barred.

A fourth area hospitals must check is state agencies, says Kusserow. "The doctor in the Philadelphia case was not even licensed," he asserts. "That's why you have to begin with the state to make sure the person is licensed to do whatever it is they are doing."

Kusserow points out that hospitals can accomplish these steps inexpensively. [Hospitals can check 750 agencies nationwide for a person for $5 or all federal agencies for $1.]

"It is not a major expense," he asserts. "When you weigh the cost of doing that against the potential liability that would come from tort liability suits, federal sanctions, or fraud investigations, it's a no brainer."

Finally, Kusserow says that compliance officers, human resource staff, and the medical credentialing committee all should be engaged in this process. Human resources staff should verify

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credentials while the medical credentialing committee approves staff privileges. "What hospitals should do is have a coordinated effort rather than have each group perform it piecemeal, which will drive up the cost," Kusserow says. ■

Nursing home abuse

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Medicare & Medicaid Services (CMS) would count as abuse. In addition, for a variety of reasons, victims, their families, and witnesses often are reluctant to report abuse.

Committee chairman **John Breaux** (D-LA) said another problem is lack of coordination among government agencies charged with oversight in this area. He said that while many agencies have it within their jurisdiction to respond to claims of abuse, all too often, no single agency has ultimate responsibility to investigate allegations.

The GAO also reported that while some research focusing on citations of nursing homes for abuse-related violations are maintained in a CMS database, these data reflect only the extent to which facilities fail to comply with federal or state regulations.

"Abuse incidents that nursing homes handle properly are not counted because no violation has been committed that warrants a citation," according to the agency.

According to health care attorney **Joe Bianculli** of Bianculli & Impink in Arlington, VA, that is not exactly correct. In fact, he says, one reason there are so many abuse citations is that they cite the abuse itself and the facility's failure to investigate properly under the same tag. "Some of the abuse citations are really 'failure-to-investigate' citations," he explains.

If a facility investigates a complaint properly and responds properly, it is up to each state agency whether to cite abuse, says Bianculli. He adds that in some CMS regions, certain memos instruct surveyors not to cite abuse if a facility had in place appropriate training, policies, and procedures, and promptly investigated, reported, and responded. "But that is by no means a universal practice by state agencies," he adds. "In fact, in many states, if you self-report, you are asking for a citation."

In addition, Bianculli says that surveyors sometimes cite "failure to determine the cause" for unexplained bruising or other injury as abuse as well. That frequently leads to citations for unexplained incidents, he says.

Bianculli agrees that nobody knows how pervasive the problem really is. He points out that the instances of abuse cited at the hearing took place years ago.

But even without any hard evidence, he fears that some lawmakers may dramatize the issue based on isolated, anecdotal horror stories.

Bianculli says a useful rule for facilities to follow is, "When it doubt, always report it." But he says the problem with that is, the more reports a facility makes, the greater the likelihood that a survey agency will conclude that an appropriate investigation was not performed or that a certain set of facts may have constituted abuse. "That pattern varies not just considerably but wildly from state to state," he says.

Delta Holloway, a registered nurse and licensed nursing home administrator, told the committee that, to make the system function better, providers must take two immediate steps. First, they must establish an efficient reporting system predicated on a clearly defined standard of abuse.

Second, they must work as partners with all parties involved in the complaint and investigation process. "With regard to identifying abuse, this is not as simple as it may seem," warned Holloway, president and quality assurance officer for Western Health Care in Boise, ID. But if the standard is clear, it will be easier to enforce. ■

E-health enforcement

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of Gardner Carton in Chicago.

Health care attorneys say most government enforcement of this area has focused on prescription drugs sold on-line.

But that may change. **Timothy Delaney**, unit chief of the FBI's health care fraud unit, recently pointed to the bureau's cyber crimes division as one of the FBI's new initiatives. "We have not

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quite figured out, if it is a health care provider and they are billing over the Internet, if that is a cyber crime or health care fraud," he says.

Health care attorneys say that is just the point. "A lot of people believe that because this is e-commerce, the basic rules don't apply, but the important point is that they do," says **Edward Kornreich**, a health care attorney with Proskauer Rose in New York City.

According to Kornreich, all of the fundamental principles regarding licensure and tax exemption and, most importantly, compliance with Stark and the anti-kickback statute apply to e-health.

"The most important thing to understand about e-commerce is that, although there are a lot of rules that will become clearer over time, just because you are in an e-commerce setting does not mean that the traditional rules do not apply," he explains.

According to Broccolo, failing to take the full spectrum of legal and regulatory issues into account early in the design phase of the web site-development process, as well as throughout the ongoing operation and maintenance of the site, may give rise to the need for significant design changes and expose the organization to the risk of adverse regulatory action.

Broccolo says these issues and the corresponding liability risks must be carefully managed through web site disclaimers, terms, and conditions of use, consents, privacy, and various other policies.

Numerous questions remain unanswered, however. Whether the interaction between the provider and the individual gives rise to a patient/provider relationship is one of them, says Broccolo.

"An interaction involving consultation, diagnosis, or advice may give rise to a 'cyber' relationship that carries all the associated ethical and legal obligations, regardless of whether payment occurs," she asserts. "A more passive interaction, such as an individual viewing educational information, may not."

Provider-patient interactions in chat rooms carry a significant risk that the information being provided will be viewed as medical advice and that the information will be misunderstood and misapplied, she adds. ■

HHS Office of Inspector General lists top priorities

Health and Human Services (HHS) Inspector General Janet Rehnquist told the House Subcommittee on Labor-HHS-Education Appropriations March 5 that her office's top priority since Sept. 11 has been making sure that the necessary infrastructure and tools exist to respond to potential future terrorist events, including bioterrorism, and other public health emergencies.

Among the other upcoming priorities are investigations into outpatient cardiac rehab programs, patient dumping, provider outreach, and quality of care in nursing homes. Also on the OIG's list of priorities are billings for clinical laboratory services and expanded use of civil monetary penalty cases to combat false claims and kickbacks. ■

Correction

The March 4, 2002, *Compliance Hotline* article, "Don't let HIPAA myths derail compliance efforts" was derived without attribution from a three-part series in the e-mail newsletter *HFMA Wants You to Know*. This newsletter is produced by the Healthcare Financial Management Association (HFMA) , which is the sole owner of all the content of the newsletter. To read the whole series, go to www.hfma.org/publications.

In addition to this oversight, two points in the *Compliance Hotline* article should be clarified. The first paragraph implies that the content of the entire article is the result of preliminary results of HFMA's membership survey on HIPAA readiness. In fact, only the first sentence of the article is a conclusion from the survey. The remainder of the article is the work of the two original authors, Tom Sadauskas and Gail Sausser.

Also, quotes were erroneously attributed directly to each of the original authors. The HIPAA myths series was a joint effort of the original authors, with support from HFMA's HIPAA@Work Task Force, and the imposition of individual quotes is inaccurate.

Compliance Hotline regrets these errors. ■