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THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

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What's a kickback? Don't assume you know

Medical College of Georgia hospital learns lesson the hard way: Beware of vendors bearing gifts

Compared to some government regulations, like HCFA's Byzantine Stark II self-referral regs, the Anti-Kickback Statute seems easy enough to understand. But don't be fooled. A recent case in Georgia, (not to mention some delicately worded advisory opinions recently released by the Office of the Inspector General) makes it clear that the government's idea of a kickback may differ sharply from your own.

The Medical College of Georgia in Augusta, a teaching hospital, didn't suspect anything was amiss when a vendor transmitting monitoring data from cardiac patients' homes to the hospital's cardiology unit offered a proposal. Instead of having the data transmitted to the vendor and then relaying it to the hospital, the company said it would be more efficient if it could install a computer and fax machine in the hospital that would directly receive the information. The hospital had only to sign an agreement pledging that the equipment would not be used for other than its intended purpose.

The hospital was shocked when it received a letter from a senior attorney in the Justice Department that accused the hospital of kickbacks, says **Andrew Newton**, associate legal advisor for the Medical College of Georgia. The letter asked the hospital to respond and to provide relevant documentation.

The irony was the hospital was not the real target of the investigation. It turned out that the vendor was under scrutiny by DOJ, which had subpoenaed the company's customer records.

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Supreme Court gives EMTALA more teeth

Hospitals hoping for relief from patient dumping rules suffered a setback after the Supreme Court ruled that a patient could sue a hospital that transferred her to a nursing home. The decision comes on the heels of a November OIG/HCFA warning that regulators are preparing a special advisory bulletin that will put more teeth in the federal anti-dumping statute.

The court decision will spur yet more dumping suits, predicts **Joseph Mattingly**, the Lebanon, KY-based lawyer who represented the patient in

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Get compliance input into clinical ethics, warn experts

If a disconnect between clinical and business ethics has created a house divided in your hospital, it's time to break down the walls.

This was a problem encountered recently by **Nicki Humphries**, compliance officer for the University of Maryland Health System in Baltimore. Recently a JCAHO team arrived at the hospital for a mock survey. The surveyors met with the hospital's bioethics committee. Instead of merely discussing clinical issues, the surveyors quizzed the committee about business ethics such as billing issues. Not surprisingly, the clinicians on the committee were not equipped to answer those questions. "Our people said, 'huh?'" Humphries recalls.

Fortunately, it was a mock survey, but Humphries says she learned a valuable lesson. Next time, someone from the compliance department will be there when the clinical ethics committee meets JCAHO.

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Kickbacks

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Newton sent a letter in August explaining the situation and enclosing the agreement the hospital signed. He has yet to receive a response.

"I don't think we did anything wrong," says Newton. Nonetheless, he says he would "shy away" from signing a similar agreement. Indeed, in hindsight the hospital probably could have used its own in-house equipment to accomplish the same tasks.

"I don't think these vendors understand how much trouble they can get hospitals in," warns **Jessy Huebner**, compliance officer for Methodist Medical Center in Jacksonville, FL. Vendors offering freebies are much less common than they used to be, now that the government has providers running scared of kickbacks, Huebner adds.

But just last week, a vendor called him and offered to let the hospital temporarily use a piece of radiology equipment. The hospital could keep the equipment in what essentially would have been a freebie arrangement, as long as it said nice things about the devices to doctors. Huebner turned the deal down.

The key to avoiding a date with your local U.S. Attorney, say experts, is not merely to avoid kickbacks, but also to avoid any appearance of impropriety. That means paying or being paid fair market value for goods and services when you are dealing with potential sources of referrals, for example.

In any event, these vendor specials often don't turn to be such bargains, warns Huebner. You might get free equipment from a vendor, only to find that there's a steep price tag when you later order parts and supplies. He's also wary of free educational seminars offered by vendors. ■

Clinical ethics

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Indeed, you can expect more JCAHO scrutiny of your compliance program, says Philadelphia attorney **Claire Obade**, who's written extensively on ethics issues. Though JCAHO has long been reluctant to delve into fraud enforcement, which it sees as uncomfortably outside its quality of care purview, the commission has come under pressure from the government to take a stronger watchdog role.

"This is definitely on their radar screen," Humphries agrees. Indeed, a surveyor recently told her that if he could stop a clinician in the hall, and that clinician could talk about business as well as clinical ethics, "that would be terrific."

Beyond satisfying JCAHO, there are strong liability reasons those who decide clinical ethics need compliance input. Clinicians are more at home discussing patient care. Yet decisions on utilization could have false claims implications as the government prepares to charge that underutilization is another form of health fraud, notes Obade. And policies regarding informing patients on various sources of care could have kickback implications, says Humphries.

To get more compliance input into the clinical ethics process, Obade suggests having someone from the compliance staff observe the meetings of the clinical ethics committee, or at least get copies of the committee's correspondence. Another solution would be to have one overall committee that handles ethics issues, with subcommittees tasked with studying various business and clinical issues. If a Joint Commission surveyor tries to raise business issues with the clinical ethics committee, "tell them they're at the wrong level and here's who they need to talk to, advises Obade. ■

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EMTALA

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the case. Claimants whose cases were dismissed by various lower courts now will have grounds to refile their cases, says Mattingly. But **Mary Grealy**, Washington, DC, counsel for the American Hospital Association, says that the facts of the case are so unique that it will have little impact.

The Supreme Court decision involved Wanda Johnson, a woman who was hit by a truck in May 1992 and taken to The Humana Hospital - University of Louisville in Kentucky. After six weeks in unstable condition, the hospital sent her to an Indiana nursing home, which in turn sent her to an Indiana hospital after her condition worsened. After Indiana Medicaid refused to pay her medical bills because she wasn't a state resident, Johnson's guardian sued Humana under the Emergency Medical Treatment and Active Labor Act (EMTALA). Her suit was filed under Section 1395 of EMTALA, which requires hospitals to properly examine and stabilize patients.

A federal district court and an appeals court both dismissed the case on the grounds that EMTALA required the plaintiffs to show that either the medical decision claiming Johnson was stable, or the decision to transfer her to a nursing home, was prompted by improper motives such as her age, race, or finances. But the high court ruled that Section 1395 of EMTALA did not require proof that the hospital acted from improper motives. The case was remanded back to the lower courts, where Mattingly expects it will be resumed or settled in the spring.

While the decision was a victory for the plaintiffs, it was not a definitive one, says Mattingly. Both sides in the case were disappointed that the court didn't give concrete guidance as to what's needed to prove patient dumping. Instead, the Supreme Court merely ruled that the question of a hospital's motives did not invalidate such a case. "This doesn't settle any of the issues," says Grealy, adding that the decision would have been momentous only if the court had ruled that the plaintiffs needed to prove the hospital acted from improper motives. "That would have raised the bar in these cases," she notes.

The key issue of the case was whether it was appropriate for the hospital to transfer a patient to another facility, Grealy argues. EMTALA was just intended to ensure that patients could get emergency care, but Johnson had received six weeks of care before she was transferred.

The federal anti-dumping statute mandates that patients must get a proper screening exam and emergency treatment, and that a patient's condition must be stabilized before he or she can be discharged, according to the OIG bulletin. An unstable patient may be transferred only if a doctor certifies that it is in the patient's best interest.

But Mattingly's advice for hospitals is to remember that stabilizing a patient for purposes of EMTALA differs from the medical definition of stabilization. "When a doctor says this patient is stabilized, he's thinking in terms of medical stabilization," he adds. But that's essentially a short-term assessment. EMTALA views stabilization as meaning a patient's condition will remain stable for the long term, and he or she can be safely transported to another location, Mattingly says.

OIG statistics show that during FY 1998, the agency settled 54 dumping cases that netted $1.8 million in penalties. In addition, it took administrative action against three doctors and a hospital. Another doctor was fined $100,000 for dumping two patients in a case that's under appeal. ■

MA Blue pays $4.75 million

Blue Cross and Blue Shield of Massachusetts has agreed to pay $4.75 million after the government charged that the company had billed Medicare for claims that should have been paid by Blue Cross group health plans.

This signals that private insurers had better check who the primary payer is before charging Medicare. More ominous for some providers, BC/BS of Massachusetts also agreed to give information to HCFA that will help the agency identify cases in which providers may have been reimbursed by both Medicare and private insurance. The company also will maintain procedures to ensure that Medicare is properly billed as a secondary payer, as well as informing HCFA of when the firm is the primary payer for a Medicare beneficiary. ■

Fraud alert leaves HHAs, DMEs holding the bag

The beleaguered home health and durable medical equipment industries have taken yet another hit with the release of the OIG's latest special fraud alert. Some experts claim that the alert, ostensibly meant to warn physicians away from the practice of rubber-stamping certifications of medical necessity, actually is designed to chill physicians' relationships with HHAs and DME suppliers.

"This is phrased for physicians, but it's really aimed at DME suppliers and home health agencies," says **Marty Gaynes**, an attorney at Schmeltzer Aptaker Sheppard in Washington, DC.

In the fraud alert, HHS Inspector General June Gibbs warns that "physician laxity in reviewing and completing certifications of medical necessity is a problem that can contribute to fraudulent and abusive practices by unscrupulous suppliers and home health providers."

Receiving benefits for giving false certifications can be prosecuted as a kickback, while even doctors who don't receive any benefits from the service — who provide it, say, as a favor for an elderly patient — are still liable if they knew or should have known that they were signing false or misleading certifications, says OIG. However, the agency does acknowledge that certification caused by "mistake, simple negligence, or inadvertence will not result in personal liability."

Reading between the lines reveals ominous signs for HHAs and DME firms, Gaynes says. In particular, the alert notes that providers are liable not just for actions they made knowingly, but also for acting recklessly. For many providers, that reckless standard of proof means "that if the government wants to make a case, it won't be hard to do it," says Gaynes. For example, if a nursing home orders huge amounts of medical equipment, a DME supplier could be liable because it didn't check that a physician ordered the items.

While the alert speaks solely in terms doctors being tricked or bribed by dishonest HHAs and DME companies, it doesn't address such situations as a physician's office that has an employee sign plans of care because the doctor doesn't want to be bothered, says **Bill Dombi**, vice-president for law at the National Association for Home Care in Washington, DC. That leaves the HHA holding the bag when it submits the claim. Nor does OIG remind physicians that they have a duty to prescribe appropriate care, even though some doctors are now afraid to refer patients for home health services, Dombi says. "I look at it as an effort to chill relations between doctors and HHAs and DMEs," he adds.

The only recourse for home health and DME companies is greater care and education, experts agree. DME suppliers need to check, for example, that supplies ordered by nursing homes actually match those ordered by doctors, recommends Gaynes. Home health agencies should also try to educate physicians on what qualifies for homebound status, for example, says **Denise Bonn** at Schmeltzer Aptaker Sheppard. But they also must be careful that educating doctors doesn't lead to accusations that they're soliciting patients, Bonn adds.

One way that home health agencies can take advantage of the fraud alert is to show it to doctors and explain why the agencies need their help in staying in compliance, Dombi says. ■

OIG considers hospice plan

OIG is asking for industry input into a model compliance plan for hospices. The agency is soliciting advice as to what danger spots exist in the hospice industry that should be addressed in a compliance program. OIG is using a similar participatory process to design model plans for the DME and nursing home industries. The deadline for hospice suggestions is March 15. ■

Hospital settles for $283,000

A Massachusetts hospital has paid $283,000 to settle federal charges that it defrauded Medicare for infusion of intravenous chemotherapy services. The Justice Department charged that The Cancer Center of Boston at Plymouth, Cape Cod, had billed Medicare between 1991 and 1995 for prolonged infusion through portable pumps. The facility billed for multiple days of infusion, when in reality the treatment was administered only on a single day, according to DOJ. ■