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FRAUD AND ABUSE

Former Heads of Georgia Medical Supply Company Indicted for Medical Fraud

U.S. Attorney for the Northern District of Georgia David E. Nahmias has announced that the former chief executive officer and chief operating officer of Orthoscript Inc., a medical supply company based in Alpharetta, Ga., were charged with defrauding Medicare of at least \$500,000 over four years, (*United States v. Isley*, N.D. Ga., No. 1:05-CR -621, charges filed 12/29/05).

Nahmias said in a written statement that the former chief operating officer, Angela D. Isley, and the former chief executive officer, James Arch Nelson, were charged with 37 counts of Medicare fraud. Isley, who also is an owner of the company, pleaded not guilty to the charges before a federal magistrate on January 10, Nahmias said. Nelson entered a not guilty plea on January 7. According to Nahmias, Isley and Nelson billed Medicare for expensive orthopedic supplies, such as shoulder braces, wrist splints, and leg braces, and supplied cheaper ones to patients. Orthoscript does business throughout the Southeast, the indictment said.

The indictment alleged that the pair instructed company employees, "often over their objections," to list incorrect product codes on claims they filed with Medicare. This practice is known as upcoding.

According to the indictment, Orthoscript was profitable for Isley and Nelson, who were paid \$950,000 and \$1.2 million, respectively, by the company in regular income and quarterly distributions from 2001 to 2003.

In the same indictment, Isley and Nelson were also alleged to have defrauded the Federal Employees Health Benefits Program in the same manner. From 1999 to 2003, the pair upcoded

their products in claims submitted to Medicare. Nahmias cited one example in which Medicare was billed \$400 for a walking boot that cost \$30.

Allegedly, the defendants also overcharged Medicare patients for their copayments.

"Those who cheat Medicare are cheating the American taxpayers who ultimately bear the financial loss," Nahmias said. "We vigorously prosecute Medicare fraud, both to vindicate taxpayers and to protect seniors from fraud."

Federal Court Reinstates Qui Tam Action Alleging Improper Billing of 'Incidental' Care

On December 30, a federal court of appeals reinstated a False Claims Act qui tam action alleging that a group of Florida medical clinics filed false reimbursement claims (*United States ex rel. Walker v. R & F Properties of Lake County Inc.*, 11th Cir., No. 04-15283, 12/30/05).

The action alleged that the false claims involved billing Medicare for services rendered by non-physicians without a physician present, as if they were rendered "incident to the service of a physician." It was alleged that the clinics knew the services did not meet the criteria of physician supervision that is necessary for billing in that manner.

The U.S. Court of Appeals for the 11th Circuit held that relator Karyn L. Walker presented sufficient evidence to raise an issue of fact as to the falsity of the billing practices of her employer, the clinics of R & F Properties of Lake County Inc. ("R&F"), the court concluded this despite the ambiguity of a Medicare regulation (42 CFR §410.26) that did not explicitly say whether a physician had to be physically present for nurse practitioner and physician assistant services to be billed as "incidental" services.

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The court said provisions from the (i) Medicare Carrier's Manual, (ii) Medicare bulletins, and (iii) expert testimony regarding the proper billing of incidental services could provide the basis for Walker's claim that R & F understood that a physician had to be physically present in order to bill for incidental services.

Also, four months before Walker filed the whistleblower action, HHS amended 42 CFR §410.26 to require that all services billed as "incident to the services of a physician" be rendered under the "direct supervision" of a physician. Accordingly, the court stated, Walker should be permitted to present evidence that services provided without physician supervision were not in compliance with the Medicare regulation.

The ruling overturned the district court decision that ambiguity in the regulation meant that R & F could not have knowingly submitted false claims to Medicare.

Higher Reimbursement for Incident Services

According to the decision, R & F received a 15 percent higher reimbursement rate when it billed its physician assistant and nurse practitioner services as incidental to physician services, rather than if it had billed the same services under the nurse practitioner's or physician assistant's own number.

Although R & F admitted that it used its physician assistants and nurse practitioners to service its Medicare patients without a physician being physically present on the premises, it argued that physicians were always available by telephone or pager.

The court found "that the Medicare regulation required that a physician be physically present in the office suite and otherwise more involved in a patient's court of care than the [R & F] physicians were and that [R & F] knew of these requirements."

PHYSICIAN-HOSPITAL RELATIONS

WV Hospital Sues Physicians for Violating Antitrust Laws by Refusing Call Without Pay

A West Virginia medical center recently alleged that a group of cardiovascular surgeons have violated the Sherman Act by attempting to force the hospital to pay them more for cardiac emergency duties. (*Charleston Area Medical*

Center, Inc., v. Rashid, S.D. W.Va., 2:05-cv-1181, filed 12/28/05)

The Charleston Area Medical Center Inc. ("CAMC"), contends the six members of the surgeons' group, known as Thoracic & Cardiovascular Associates ("TCA"), are refusing to serve on cardiovascular trauma emergency call duty in a complaint filed Dec. 28, 2005, with the U.S. District Court for the Southern District of West Virginia. According to CAMC, this coerces it to pay each surgeon \$2,000 for each day that he or she are on call, whether or not they are actually called to treat a patient.

CAMC accuses the group of violating Section 1 of the Sherman antitrust law and further asks the court to enjoin the surgeons from these "unlawful practices," by awarding CAMC treble damages.

Surgeons Have Already Sued

TCA, who earlier filed its own lawsuit in a state court against CAMC, says it is seeking to be treated like other specialists who are paid for on-call days. CAMC claims it has offered the surgeons \$2,000 for each day that they are actually called to the trauma center "repeatedly".

HOSPITAL-EMPLOYMENT RELATIONS

Applicant Prehire Release

In a recent article in a national trade magazine, a lawyer discussed the potential liability to hospitals for failing to provide negative background information about a former employee to a prospective employer. In t his kind of work, advice has typically been to confirm dates of employment with no additional commentary.

Most employers provide only name, rank and serial number because they have consistently received bad advice which warned them not to provide more. In general, commentators are not aware of any duty by a former employer to provide information to a prospective employer unless the former employer knows the individual will pose a threat to health and safety in the position he is seeking. In some cases, the previous employer, by affirmative statement or misrepresentation by omission, may have misled the prospective employer about the individual's qualifications. Some have spoken out against the policy of refusing to provide information for the following reasons:



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First, it is bad public policy. If employers will not share reference information, individuals with inappropriate backgrounds for the jobs for which they have applied will be hired.

Second, it creates a disingenuous "wink and nod" system of indirect signals about someone's background. For example, experienced human resources managers dealing with their brethren ask, "Although you can't tell me any details about this applicant's prior employment, tell me if the former employee is subject to rehire?" When the answer is "No", the individual's chances of being hired by the inquiring employer go to zero. However, a person may not be subject to rehire for reasons which would not adversely affect their employment with the next employer.

Third, there is a simple solution to the author or human resources directors conundrum: Ask the reference checker if he has a signed release from the applicant and if not, why not? A human resources department should have included on the application or in the prehire packet a release which the applicant must sign to be considered for employment. All potential employees should secure releases and complete personnel file information.

Finally, some attorneys overstate the problems in this area. Attorneys representing applicants who were rejected on the basis of disclosures made pursuant to their releases have called me and threatened suit against employers, but suits are rare. There is little or no risk if the personnel file disclosure is made pursuant to a release. Unfortunately many employers still will not disclose, based upon the advice they have received. By analogy, the same thing is happening with regard to HIPAA releases. Although the law provides that a faxed release or a copy is as good as the original, and receipt of the release authorizes disclosure; some health care entities cannot get records from hospitals and other health care institutions because their attorneys have told them they cannot accept anything but an original document.

The article explains that in one-half of the states, there are reference immunity statutes. However, the article does not reference that there is also a qualified privilege for disclosing "need to know" information in business or other important communications. This privilege is broader in scope in many states than reference immunity statutes. This area deserves additional attention by most employers and their counsel.

HEALTHCARE COMPLIANCE

A Brief Overview of the Georgia Peer Review Privilege

Georgia law recognizes that healthcare professionals often meet to review the successes or failures of a particular procedure or of an individual's practice and that a candid discussion is vital to the success of that review process. *Emory Univ. Hosp. v. Sweeney*, 220 Ga. App. 502, 504, 469 S.E.2d 772, 775 (1996). Accordingly, the law protects against liability from claims based upon peer review activity and shields from discovery documents and testimony used or heard at a meeting of a peer review organization. O.C.G.A. §§ 31-7-130 et seq, 31-7-140 et seq.

In order to qualify for the peer review privilege, an entity must be either a "review organization" or a "medical review committee" ("MRC"). Review organizations include a broad range of medical and administrative personnel. O.C.G.A. § 31-7-131(3). A review organization "engages in or utilizes peer reviews," O.C.G.A. §§ 31-7-131(3)(B), which is defined, in part, as "the procedure by which professional health care providers evaluate the quality and efficiency of services ordered or performed by other professional health care providers." O.C.G.A. § 31-7-131(1). The peer review process must be conducted for the purpose of improving the quality of healthcare, reducing morbidity and mortality, or evaluating claims made against healthcare providers. O.C.G.A. § 31-7-131(B).

Medical review committees are similar to review organizations, but the Code narrowly defines their composition and scope. *Patton v. St. Francis Hosp.*, 246 Ga. App. 4, 7, 539 S.E.2d 526, 529 (2001). Members of medical review committees ("MRCs") must be traditional healthcare providers. O.C.G.A. § 31-7-140. As described by one court, an MRC is a "'grass roots' committee formed to make in-house examinations of the adequacy of the treatment afforded its patients." *Davenport v. Kutner*, 182 Ga. App. 467, 469, 356 S.E.2d 67, 68-9 (1987), rev'd on other grounds, 257 Ga. 456, 360 S.E.2d 586 (1987). An MRC may need to operate pursuant to bylaws to successfully raise the privilege. MRCs also review more limited matters than review organizations. It may (1) work to evaluate and improve the quality of health care; or (2) determine that the health services rendered were professionally indicated or performed in compliance with the applicable standard of care; or (3) examine whether the providers reasonably considered the cost of that care. O.C.G.A. § 31-7-140.

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These privileges can protect review organizations, MRCs and their members from at least civil liability for matters arising out of peer review activity, and the privilege places an embargo on the discovery of materials submitted to and used by peer review organizations. The immunities are frequently raised in claims of wrongful discharge brought by healthcare providers. Members of review organizations who act without malice are afforded immunity from any alleged criminal and civil liability arising out of an act taken in connection with peer review activities. O.C.G.A. § 31-7-132(a). Nonmembers who provide information to a review organization are also protected so long as they did not knowingly provide false information to the committee. O.C.G.A. § 31-7-132(b). MRC members have more limited immunity. First, members of an MRC are shielded only from civil, and not criminal, liability. O.C.G.A. § 31-7-141. Moreover, the immunity applies only in actions brought by “providers of health services” for actions taken within the scope of their duties as members of an MRC. *Id.* Actions arising in tort or contract by patients against healthcare professionals are not affected by the immunity provisions. *Id.* Beyond the immunity provisions, the peer review privilege also bars the discovery of information used by and created for review organizations and MRCs. O.C.G.A. §§ 31-7-133 (review organizations); 31-7-143 (MRCs). Identical statutory language addresses the documents and testimony before MRCs. O.C.G.A. § 31-7-143.

Legislators included several statutory exceptions to the immunity and discovery aspects of the peer review privilege, including acts motivated by “malice,” O.C.G.A. §§ 31-7-132, 31-7-141, and the discovery of “underlying data,” O.C.G.A. §§ 31-7-133(a), 31-7-143. Members of review committees and MRCs may also be called to testify regarding what they knew before the review organization met (but not what was discussed before the committee). O.C.G.A. §§ 31-7-133(a), 31-7-143. In addition, healthcare entities may not successfully raise the privilege to prevent disclosure of peer review documents (1) to state agencies, JCAHO, or other national accreditation bodies; (2) in licensing actions where the effectiveness of the peer review system is challenged; or (3) in wrongful termination and exclusion actions against managed care entities when the documents provide the “specific reasons” for the termination or were part of the “proceedings related to such provider’s exclusion or termination.” O.C.G.A. § 31-7-133(b). However, if matters are inadvertently disclosed, or disclosed pursuant to one of the statutory exceptions, the documents will likely remain privileged.

The Georgia peer review privilege can be a powerful shield in the arsenal of defenses used by healthcare professionals and entities.

[This is an excerpt from a larger article entitled “The Shield Remains: An Overview of the Georgia Peer Review Privilege,” which was published in the December 2005 edition of the Georgia Bar Journal.]

HOSPITAL MERGERS AND FTC

Lessons in Unscrambling an Egg the Federal Trade Commission Way: In the Matter of Evanston Northwestern Healthcare Corporation

On October 20, 2005, an Administrative Law Judge (“ALJ”) of the Federal Trade Commission (“FTC”) sent shockwaves through the antitrust bar and the healthcare industry when he issued an opinion requiring the unwinding of a merger consummated in January of 2000 involving three Chicago-area non-profit hospitals. Pursuant to the merger, Evanston, Glenbrook and Highland Park Hospitals merged to form Evanston Northwestern Healthcare Corporation (“ENH”). More than four years following the merger, counsel for the FTC filed a complaint alleging that the merger violated Section 7 of the Clayton Act, 15 U.S.C. § 18, by substantially lessening competition in the relevant market for acute care inpatient services. The ALJ’s decision generally to accept the FTC’s allegations creates great concern for those who have previously consummated mergers or acquisitions, those planning such transactions in the future and those who advise them. The text of the ALJ’s decision may be found on the FTC’s web site: www.ftc.gov, Docket No. 9315.

Most challenges to mergers and acquisitions occur prior to a transaction’s closing and spring from the pre-merger filings required for certain transactions by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (“HSR Act”). While the ENH merger appeared to have met the minimum threshold requirements for review under the HSR Act, ironically, the parties obtained advice from the FTC that no filing was required because Northwestern Healthcare Network (the “Network”) was the sole member of each such hospital, i.e., the single Network already held the assets of all three hospitals. The ALJ nonetheless did not accept the hospitals’ argument that the merger likewise should be considered something of a non-event for Clayton Act purposes.

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The FTC's determination to challenge the ENH merger should not be viewed in isolation. One must understand that the FTC in recent years has suffered a number of high-profile losses in their efforts to challenge several hospital mergers. The FTC brought each of those cases prior to the consummation of the challenged transactions and had enormous difficulties convincing the courts that such mergers were likely to produce substantial anticompetitive results in properly defined markets. Partially because of those embarrassing losses, the FTC has undertaken to review certain consummated hospital mergers.

While the FTC's counsel may have decided to review the ENH merger in any event, that decision more than likely was influenced by customer complaints. The ALJ's decision makes it clear that a number of managed care organizations may have complained to the FTC because ENH was able to obtain more favorable terms from them than the separate hospitals had been able to obtain prior to the merger. The ALJ also repeatedly cited testimony from managed care representatives to support his decision. The FTC and the ALJ left no doubt that it is the first stage competition among hospitals to obtain contracts with managed care organizations (the customers in this relationship) that is of paramount importance to the FTC, not the second stage competition among hospitals for patients after obtaining managed care contracts.

A series of unfortunate statements by executives also turned out to be quite harmful to ENH's cause. These statements suggested that a primary benefit of the merger was the strengthening of ENH's negotiating posture with managed care organizations (and the resulting price increases obtained by ENH). Those executives may have been better advised to tout the efficiencies created by the merger, improvements in quality of care, etc. It must be remembered that the FTC is most interested in fostering competition that leads to lower prices or better services and does not respond favorably to transactions where the parties suggest higher prices or the lessening of competition as a primary motivation.

The ALJ analyzed each reason offered by ENH for the price increases and ultimately dismissed them. For example, the ALJ did not credit ENH's assertion that prior to the merger Evanston did not fully understand the demand for its services and, consequently, had inadequately priced its services. Although the ALJ recognized that quality of care improvements were made following the merger, he determined that most were not merger specific and those that were merger specific did not outweigh the anticompetitive effects of the merger.

The decision to unwind the ENH transaction presents a legal and practical nightmare for the parties involved and should give pause to those who have completed mergers in recent years, especially where the merger may have fostered price increases. The ENH decision also complicates the advice that should be given in the stages leading to such a merger.

The ENH saga no doubt will continue. Both ENH and the FTC's complaint counsel have appealed the ALJ's decision to the full body of commissioners of the FTC. A subsequent appeal to a United States Circuit Court may follow that decision. Perhaps a more rational result will spring from such appeals.