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HEALTHCARE LITIGATION NEWS

Essential Legal Updates for the Healthcare Industry

Spring 2007

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MICHIGAN SUPREME COURT HOLDS THAT MEDICAL STAFF DECISIONS ARE COVERED BY THE ELLIOTT-LARSEN CIVIL RIGHTS ACT

In the Spring 2006 Newsletter, we noted that the Michigan Supreme Court agreed to hear a physician's appeal of the Michigan Court of Appeals' decision in *Haynes v Neshewat et al.* in early 2006. As you may recall, in that case, an African-American physician sued Oakwood Hospital, claiming that the hospital's racially discriminatory behavior towards him deprived him of the opportunity to fully and equally use Oakwood's facilities. The physician's claim was predicated on the assumption that the hospital was a "public accommodation" under the Elliott-Larsen Civil Rights Act and therefore, it could not engage in discriminatory conduct that interfered with the physician's staff privileges. Upon hearing the case, the Michigan Court of Appeals had concluded that since hospitals do not afford staff privileges to members of the general public, Oakwood Hospital was not a place of "public accommodation." On March 28, 2007, the Michigan Supreme Court reversed the Court of Appeals and concluded that Oakwood is a public accommodation and therefore, as an individual protected by the Civil Rights Act, the physician was entitled to pursue his discrimination claim against Oakwood.

In a unanimous decision, the Supreme Court construed the language of the Civil Rights Act and determined that it afforded protections to individuals who were denied privileges offered by a public accommodation. It concluded that the protections afforded by the statute were not limited to just those accommodations that were used by all members of the public. In particular, the Supreme Court stated "[The Civil Rights Act] protects the rights of individuals. Individuals, not members of the public, are protected from the denial of the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations. Nowhere within the wording of § 302(a) is it required that the goods, services, facilities, privileges, advantages, or accommodations be offered to the public. We will not read into the statute a limitation that is not there. We hold that [the Civil Rights Act] forbids unlawful discrimination against any individual in a place of public accommodation, not just against members of the public."

The decision is significant. It overturns decade-old precedent and along with the Michigan Supreme Court's recent decision in *Feyz v Mercy Memorial et al.*, it opens private hospitals to potential litigation over medical staffing decisions. As such, hospital boards will need to be even more circumspect than they already are as they engage in peer review and make decisions regarding applications for appointment or reappointment to their medical staff, the scope of physician privileges and the way physicians are disciplined in connection with patient care or professional behavior concerns.

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COURT AWARDS ATTORNEY FEES AGAINST FEDERAL GOVERNMENT IN QUI TAM CASE

The United States justice system ordinarily requires that each party bear its own attorney fees in contested matters before the courts. Nevertheless, the prevailing party in litigation many times still feels like a loser after absorbing a hefty bill from its attorneys. And, in cases brought by the government or qui tam relators for alleged improper billing to the Medicare or Medicaid program, incurring substantial attorney fees is only one potential adverse outcome for a provider. The provider can also be subjected to potential criminal liability, or huge damage awards and civil penalties for improperly billing these programs.

A recent case decided by a federal court in Texas, however, demonstrates that government authorities do not always have "the final say" in these billing disputes. In *United States of America v Medica-Rents*, a disgruntled former employee, whom the court found was motivated by a desire to inflict "maximum damage" on the company's president, filed a qui tam action against Medica-Rents. The suit alleged that Medica-Rents, a durable medical equipment company, had systematically over billed Medicare (by using the wrong HCPCs code) for nonpowered, palliative air mattresses. Although none of the decisions of the court specify the total amount of alleged overpayments, penalties and other damages sought by the government, the amount at issue was probably quite large inasmuch as Medica-Rents reportedly expended $4,895,218.86 in attorney fees defending the case.

After the original filing of the case, the United States Attorney's Office decided to intervene in the action and take over the prosecution of the case. The government claimed that between 1994 and 1996, the company submitted fraudulent billings in violation of the federal False Claims Act. The billings were allegedly false and fraudulent due to the fact that the company billed for its mattresses under code EO277 which had an official descriptor "alternating pressure mattress." Since according to the US Attorney, the company's mattresses were neither powered nor were true mattresses, the mattresses could not be considered alternating pressure mattresses. Thus, the company allegedly made false statements when it decided to bill for its mattress under code EO277.

In September 2006, the United States District Court for the Northern District of Texas disagreed with the government, and granted Medica-Rents summary judgment on the alleged violations of the federal False Claims Act. Discovery showed that Medicare carriers allowed and in some instances authorized other mattresses (which were non-alternating pressure products) to be billed under code EO277. Further, prior to billing under code EO277, the company inquired of several carriers whether it could properly bill under EO277, and had received conflicting advice. Finally, the company received a letter from the government directing it to use EO277 when billing for the mattress. Based on this evidence, the court found that the company's use of the EO277 was neither false nor fraudulent.

Despite this decision, the government continued to press other claims that it was entitled to recover the amounts it paid the company under code EO277. The government claimed it was entitled to repayment due to "mistake" in the payment or due to alleged unjust enrichment of the company in receiving the payments. These claims proceeded to trial, and once again, Medica-Rents prevailed. After expending huge amounts in attorney fees in the lengthy litigation, Medica-Rents asked the court to award it attorney fees in defending the case. In a decision made in December 2006, the court found that Medica-Rents was entitled to recover its fees due to the government's continued bad faith in pursuing the litigation.

This extraordinary case offers a number of lessons for providers operating in today's health care environment. First, providers must understand that the government can seek to impose liability and penalties even in matters where honest differences of opinion over proper billing, or innocent errors, occur. Second, when seeking billing guidance from a government entity, a provider should carefully document all communications. Third, the provider should seek advice from reimbursement or coding experts, and competent legal counsel, when questions arise over billing (especially if such billings involve substantial amounts). Fourth, the mere fact that government investigators or US Attorneys claim that certain billings are false or fraudulent (or medically unnecessary) does not necessarily mean that the billings are unlawful. US Attorneys and government investigators are not medical or industry experts, and in many cases are not well-informed on the issues presented by particular cases. In such circumstances, they may be unduly swayed by complainants who have their own agendas to pursue. If a provider is served with a government or qui tam suit, it should therefore consult with counsel who have handled and are familiar with these cases.

THE McNULTY MEMORANDUM: WHAT PRIVILEGE PROTECTIONS CAN HEALTHCARE CORPORATIONS EXPECT?

In December 2006, the Department of Justice (DOJ) issued revised guidelines covering the federal prosecution of business organizations. These new guidelines, authored by Deputy Attorney General Paul McNulty and referred to in shorthand as the "McNulty Memorandum," were DOJ's attempt to revise corporate criminal and civil prosecution policies established in 2003. These earlier policies were prepared by then-Deputy Attorney General Larry Thompson.

The policies in the "Thompson Memorandum" were an assault on the attorney-client privilege and the attorney work product doctrine. In particular, these policies permitted the federal government to routinely ask for waivers of the attorney-client privilege and the attorney work product doctrine and to condition its treatment of corporate targets or defendants based on their willingness to waive the protections afforded by these privileges. Thus, both the corporate and legal communities criticized the Thompson Memorandum, stating that its policies not only had a chilling effect on the nature of disclosures corporate officers, directors and employees would make to their attorneys, but also penalized those corporations that sought protection under the privileges because they would be subject to harsher fines and penalties.

The McNulty Memorandum was, in theory, supposed to revise the troubling aspects of the Thompson Memorandum. Instead, the McNulty Memorandum guidelines do not significantly deviate from the Thompson Memorandum policies. Although the McNulty Memorandum establishes new procedures for obtaining corporate waivers of the attorney-client privilege and the attorney work product doctrine, it still allows the federal government to request these waivers and, in some circumstances, to consider a company's decision to waive these privileges as part of the government's decision to indict, prosecute or sanction the company. The McNulty Memorandum also permits the federal government to garner waivers of factual information and attorneys' opinions.

The McNulty Memorandum did little to alter the federal government's prior policy of requesting and obtaining waivers. The guidelines do not have the force of law and they are not binding on federal prosecutors. As such, it is not likely that healthcare corporations can expect that the federal government's policies regarding corporate indictments, prosecutions or investigations will change significantly.

Congress may be willing to provide healthcare entities (and other organizations) with some relief from the McNulty Memorandum guidelines. In 2006 and again in January 2007, Senator Arlen Specter introduced in the Senate the Attorney-Client Privilege Protection Act, a bill designed to provide appropriate protection for attorney-client privileged communications and attorney work product. The proposed Act would amend the federal criminal code to prohibit any United States agent or attorney, in any federal investigation or criminal or civil enforcement matter, from demanding, requesting or conditioning treatment on the disclosure by an organization or person affiliated with that organization, of any communication protected by the attorney-client privilege or any attorney work product. It would also prohibit any United States agent or attorney from conditioning a civil or criminal charging decision on an organization's decision to (1) assert either of the privileges, (2) provide counsel to or contribute to the legal expenses of its employee, (3) enter into a joint defense agreement with an organization employee, (4) share information with an organization employee, or (5) refuse to terminate an employee. Lastly, under the proposed Act, no United States agent or attorney could demand or ask that an organization or one of its employees not do any of the acts itemized above.

Senator Specter's bill is being considered in the Senate Judiciary Committee and no significant action has occurred since January 2007. A subcommittee of the House Judiciary Committee held on March 8, 2007, a hearing on the McNulty Memorandum and its impact on the attorney-client privilege. Arranged by the Association of Corporate Counsel, the hearing ended with the subcommittee members who were present agreeing that the House should introduce its own version of the Senate bill. Thus, it is possible that Congress will ultimately provide some protection to organizations facing federal investigation, indictment or prosecution who hope to rely on the attorney-client privilege and work product doctrines. In the meantime, healthcare entities facing the threat of a federal government investigation, indictment or prosecution should contact counsel to ensure that they obtain the full benefit and protection of the privileges they are entitled to under the law.

OIG 2007 WORK PLAN TARGETS HEALTH-CARE PROGRAM AREAS THAT WILL FACE GREATER SCRUTINY IN 2007 AND 2008

With 2007 underway, healthcare providers should be aware of the Department of Health & Human Services (HHS) Office of the Inspector General's (OIG) 2007 Work Plan, which sets forth several programs and activities that are likely to be the subjects of heightened scrutiny, whether in the form of an audit or a direct investigation by the OIG. Indeed, several Centers for Medicare & Medicaid Services (CMS) programs are targeted for reviews and/or investigations in 2007 and 2008. For example:

Nursing Homes and Nursing Facilities

OIG will examine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. It will also be reviewing the medical necessity of psychotherapy services to nursing facility residents. And, it will be assessing the implementation of Medicare Part D in nursing homes to confirm, in part, that residents are receiving under Part D the drugs that they need.

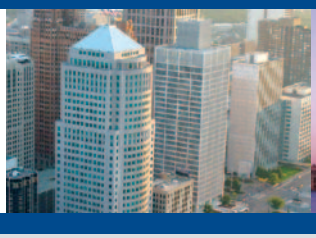
Physicians and Other Healthcare Professionals

Services provided or arrangements entered into by individual healthcare providers will face in depth review. OIG expects to continue its review of the arrangements healthcare professionals have with billing services and to determine the effect these arrangements have on billings. In addition, OIG will be looking at several services offered by healthcare providers and whether the services are reasonable and medically necessary and whether the billings for these services are proper. Targeted services include, among others, pathology laboratory services, cardiography and echocardiography services, physical and occupational therapy services, Part B mental health services, wound care services and services performed "incident to" a physician's professional services.

Durable Medical Payments for Beneficiaries Receiving Home Health Services

The OIG will scrutinize medical records for DME items and supplies provided to beneficiaries receiving home health agency services to determine whether the items and suppliers were reasonable and necessary. The federal government will pay specific attention to therapeutic footwear furnished by individual suppliers and DME items such as power wheelchairs, wound care equipment and orthotics.

The OIG's reviews are not limited to CMS programs only. OIG will also engage in evaluations of programs in HHS' other operating divisions, which include the Agency for Health Care Research & Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, the Indian Health Service, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Administration for Children & Families and the Administration on Aging. For more information on the targeted areas of investigation in each of these divisions or on other CMS programs facing review, readers can contact Miller Canfield's healthcare litigators or can review the OIG's Work Plan directly at the Department Health & Human Services website.



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