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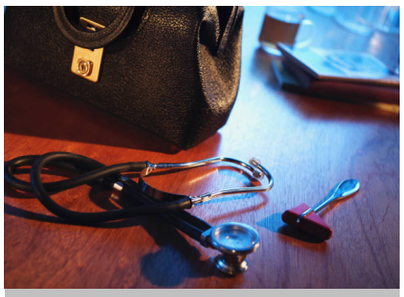
HEALTHCARE LITIGATION NEWS

Essential Legal Updates for the Healthcare Industry Spring 2006



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Michigan Supreme Court to Decide Whether Medical Staff Decisions Are Subject to Court Review

Hospital decisions to grant or deny applications for appointment or reappointment to its medical staff, to delimit the scope of physician privileges and to suspend or otherwise discipline physicians for patient care or professional behavior concerns are an important aspect of the health care industry. These decisions have ramifications for the careers of physicians, the hospital workplace and the provision of appropriate patient care.

For almost twenty-five years, the medical staff decisions of private hospitals have not been subject to judicial review, and hospital governing boards have been essentially free to make most medical staff decisions without fear of interference by state courts. The Michigan Supreme Court, however, is revisiting this long-standing practice. As a result, it will either establish new legal standards for medical staff decisions or reaffirm the long-standing principles that have granted hospital boards wide latitude in making medical staff decisions.

In the matter currently before the Michigan Supreme Court, Dr. Bruce Feyz issued standing orders to nurses at Mercy Memorial Hospital to ask patients who presented at the hospital which medications they were taking at home and how these medications were administered. The hospital administration reacted unfavorably to these orders and instructed the hospital nurses to disregard them. When Dr. Feyz disputed this action, the hospital eventually placed him on indefinite probation. The doctor responded by filing suit in state court.

The hospital asked a state trial court to summarily dismiss the action, citing the well-established judicial nonreviewability doctrine. Although the trial court dismissed the action, the doctor appealed and the Michigan Court of Appeals decided in *Feyz v Mercy Memorial et al.,* 264 Mich App 699 (2005) to reverse the trial court decision. In a lengthy opinion authored by Judge Sawyer, the Court of Appeals panel stated that previous Court of Appeals decisions barring judicial review had "drifted" from the nonreviewability doctrine's original intent, and improperly expanded the scope of the doctrine. The court opined that, rightly understood, the nonreviewability doctrine merely stands for "the modest proposition that a private hospital is subject only to the legal obligations of a private entity," and "not to the greater scrutiny [afforded to] a public institution." Thus, the medical staff decisions of hospitals may be subject to judicial review to the same extent the actions of any private entity would be open to such review. For these reasons, the court held that the doctor was free to pursue most of his claims against the hospital in the trial court.

Under established rules of *stare decisis*, the *Feyz* panel was bound by earlier appellate decisions that applied the nonreviewability doctrine. Although the *Feyz* court attempted to demonstrate that its decision was consistent with the historic nonreviewability doctrine, the fact remains that its decision was a substantial departure from prior decisions of the Michigan Court of Appeals.

In December 2005, the Michigan Supreme Court agreed to hear the hospital's appeal of the Court of Appeals' decision. If the Supreme Court upholds the Court of Appeals' decision, the ability of hospital governing boards to make medical staff decisions without court review may become much more limited. Physicians may have more opportunities to challenge hospital medical staff decisions in court. And, peer review of physician practices may require even more careful analysis to avoid potential legal pitfalls.

These same potential consequences may also be implicated by another case currently before the Michigan Supreme Court. On January 13, 2006, the Michigan Supreme Court agreed to hear a physician's appeal of the Michigan Court of Appeals' decision in *Haynes v Neshewat et al*.

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In that case, Oakwood Hospital's Medical Executive Committee recommended that a particular physician initiate various corrective actions to address certain professional behavior concerns. The physician, an African-American, brought suit against the hospital claiming, among other things, that he had been discriminated against on the basis of race in a public accommodation. The physician's claim was predicated on the allegation that the hospital was a "place of public accommodation" and therefore, could not discriminate against him in making its medical staff decisions.

The Michigan Court of Appeals, however, noted that hospitals do not grant medical staff membership to members of the general public. Rather, hospitals grant staff privileges only to physicians who meet certain specified criteria. Thus, as these privileges are not afforded to members of the general public, the court held that the physician could not properly claim that the hospital unlawfully refused to afford him access to the privileges of a place of public accommodation. Consequently, the appellate court refused to open the door to further review of the hospital's medical staff decision. The state's high court will now have the opportunity to clarify whether medical staff decisions are covered by the public accommodations provisions of the Michigan Elliott Larson Civil Rights Act and thus, subject to judicial scrutiny.

In short, the scope of the state courts' reviewability of hospital medical staff decisions will be analyzed and affected by the Michigan Supreme Court's decisions in both *Haynes* and *Feyz*. Consequently, both cases will bear watching, as their outcomes will have important consequences for hospitals, physicians and healthcare entities.

Michigan Authorizes Civil Lawsuits under Medicaid False Claims Act

As of January 3, 2006, the State of Michigan adopted amendments to its Medicaid False Claims Act that will allow any person to bring a civil action on the state's behalf in order to recover losses due to Medicaid fraud. The amendments will also provide "whistleblower" protections to employees who initiate or participate in proceedings under the Act.

Michigan's Medicaid False Claims Act aims to curb fraudulent and false practices by Medicaid providers. Generally speaking, the Act prohibits persons from engaging in various types of fraudulent conduct including:

- making false statements in applying for Medicaid benefits;
- making false representations of fact for use in determining rights to Medicaid benefits;
- concealing or failing to disclose an event that affects a person's right to receive Medicaid benefits;
- soliciting, offering or receiving kickbacks or bribes in connection with goods or services paid for by Medicaid;
- making false statements in order to obtain certification as a hospital, skilled nursing facility, immediate care facility or home health agency;
- entering into an agreement or scheme with others to defraud the state by facilitating the payment of a false Medicaid claim;
- making a false Medicaid claim to a state employee or officer; and
- making a Medicaid claim that falsely represents that goods or services provided were medically necessary.

The Act affects a variety of Medicaid providers from hospitals to physicians, medical transportation agencies to pharmacies, laboratories to nursing home facilities and physical therapists to providers of diagnostic services.

As amended, the Act now contains several new provisions of which all Medicaid providers should be aware. In particular, the Act now authorizes ***any person*** to initiate a ***civil suit*** against another person that violates the Medicaid False Claims Act. Any civil action brought under the Act (routinely referred to as *qui tam* lawsuits) cannot be dismissed until the Attorney General's office has been notified and had an opportunity to appear to oppose the dismissal. Any complaint filed in a qui tam lawsuit remains under seal when filed and will not be served upon a defendant until the Attorney General decides whether to intervene. The Attorney General has 90 days after filing of the complaint to decide whether to intervene in the case. Unfortunately for providers, even if the Attorney General declines to intervene at the onset of litigation, the person filing the qui tam lawsuit may proceed with his or her case. And, the Attorney General's

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office is free to intervene in the suit at a later date if it shows good cause and demonstrates that the late intervention will not affect the rights or status of the person who initially brought the qui tam action.

If the person who files the qui tam suit prevails against a provider, the provider will have to pay the person his or her necessary expenses, costs, reasonable attorney fees and anywhere from 15-30% of the assessed monetary damages depending on whether the Attorney General intervened. This is in addition to the Act's already existing requirement that a person who receives a Medicaid benefit by way of fraud, fraudulent representation or knowing concealment must forfeit and pay a civil penalty equal to the full amount the person received plus triple the amount of damages suffered by the state as a result of the person's conduct. If the Attorney General's office intervenes, it is also authorized to recover from a provider all costs the state incurred in the litigation, including the cost of investigation and attorney fees.

Under the Act, employers are prohibited from discharging, demoting, threatening or otherwise discriminating or retaliating against an employee who initiates, assists or participates in a Medicaid qui tam action. Any employer violating the Act in this regard will be required to reinstate the employee to his or her position without a loss of seniority, award the employee two times the amount of lost back pay and interest, and compensate the employee for any special damages.

The Act does include at least one protection for providers. If a person proceeds with a civil action under the Act after the Attorney General has declined to intervene and a court finds the action to be frivolous, the provider is entitled to its reasonable attorney fees and expenses and possibly punitive damages up to $10,000.

Out of the state's $8 billion Medicaid budget (which accounts for about 25% of the state's general fund revenue), Michigan loses approximately $240 million to $800 million to Medicaid fraud per year. In turn, Michigan's past Medicaid fraud investigations have only recovered about $7 million annually. States with civil "qui tam" legislation have recovered anywhere from 2-5 times that amount. Thus, these new amendments were passed with the hope of providing the state with an effective way of fighting fraud and recovering more money for the state. Given the significant financial incentive for insiders to initiate claims, providers can expect to see a number of Medicaid state-based qui-tam lawsuits going forward. And, in light of the current economic climate and the significant amount of state revenue lost to Medicaid fraud, providers can expect that the Attorney General's office will intervene in a high percentage of these suits.

Obviously, Medicaid qui tam litigation has the potential to be very costly for a provider to defend and even more costly if the provider's defense is unsuccessful. In order to insulate against, or at the very least minimize, Medicaid False Claims Act liability, providers should carefully select, educate, supervise and monitor those contractors or employees who submit Medicaid claims on their behalf. Providers should also reward employees and other insiders for reporting within the organization information about potentially false or fraudulent claims that are being made on behalf of the organization and ensure that any whistleblower (internal or external) is not penalized for reporting the fraud. Providers should have a system in place for investigating and addressing these reports, and correcting and reporting any wrongdoing. These measures should be continually employed by providers so that all employees and insiders understand that compliance with fraud and abuse laws like the Medicaid False Claims Act are part of an organization's ethos. And, providers should regularly consult with a knowledgeable attorney to ensure that they and their employees are aware of acceptable billing practices and current fraud and abuse regulations and laws.

In some instances, it may be too late to forestall an employee or insider from initiating a Medicaid qui tam action. A Medicaid provider should suspect a qui tam action has been filed against it if data is missing from its files, a particular employee is accessing an unusual number of files (a fact that is sometimes detected through software tracking) or a particular employee is coming in after hours or staying late on a regular basis without reason or under unusual circumstances. If a provider suspects a Medicaid qui tam suit has been filed against it, it should promptly engage experienced counsel who can evaluate the merits of the suspected suit, interface with the plaintiff and the Attorney General's Office once the complaint is unsealed, and manage any damage caused by the filing of the qui tam suit.

For more information on the recent amendments to the State of Michigan's Medicaid False Claims Act, please consult Michigan's Public Acts of 2005, Act No. 337 or Enrolled House Bill No. 4577.

Federal Government Requires Employee Education about Federal and State False Claims Laws

On February 1, 2006, the United States Congress passed legislation requiring certain health care organizations to educate their employees about federal and state laws addressing false claims and providing protections for whistleblowers.

The legislation, signed into law on February 8, 2006 and effective January 1, 2007, mandates any entity ***that receives or makes annual payments of $5 million or more under a state Medicaid plan*** to establish and adopt written policies about these false claims laws for all its employees (including management), contractors and agents. These policies must include detailed information about the following:

- the federal False Claims Act;
- the administrative remedies for false claims and statements as established in the Program Fraud Civil Remedies Act of 1986;
- any state laws addressing civil or criminal penalties for false claims or statements;
- the whistleblower protections afforded under these federal and state laws; and
- the roles of these laws in preventing and detecting fraud, waste and abuse in federal health care programs.

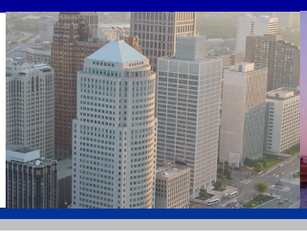
In addition to this information, the policies must also include detailed provisions that set forth the entity's policies and procedures for detecting and preventing fraud, waste or abuse within the organization. And, any employee handbook or manual must specifically address and discuss all of the topics listed above.

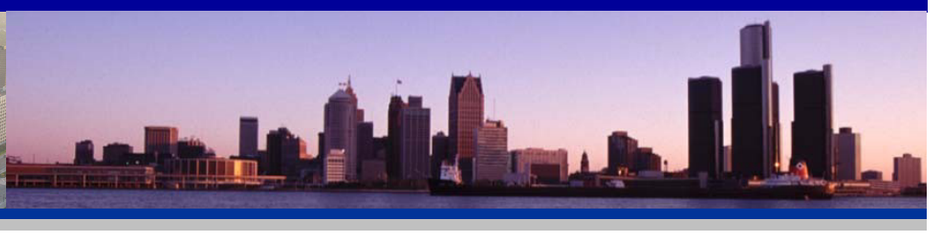
Establishing and adopting these policies is a condition to payment under a state Medicaid plan so providers can expect that the failure to institute these educational requirements may trigger potential federal or state false claims act liability.

The new education requirement is most onerous for those providers who do not have any internal policies or procedures to address fraud, waste and abuse within their organizations. In order to comply with this requirement, these entities will have to draft and adopt policies and guidelines that require employees to comply with all applicable laws and regulations, identify conduct that is fraudulent, encourage employees to recognize and report fraudulent behavior and provide for mechanisms that remedy and correct any such behavior. Even those entities with some policies in place may want to contact legal counsel to ensure compliance with this law.

The specific language requiring this employee education can be found in the Deficit Reduction Omnibus Reconciliation Act of 2005 (or Senate Bill 1932 § 6032).

For further information about this legislation or other healthcare matters contact the authors David French (734.668.7783) or Sonal Mithani (734.668.7786).





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