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News for North Carolina Hospitals
from the Health Care Attorneys of Poyner Spruill LLP

# OIG Approves Multiple Compensation Methods for Paying Physicians to Take Hospital Call

*by Wilson Hayman*

Few issues today in hospital-physician relations are more difficult and controversial than how to ensure adequate physician on-call coverage for a hospital's Emergency Department (ED). While hospitals' paying of physicians on the medical staff to provide on-call coverage once was considered unthinkable by hospital management, it has become commonplace in many communities. Factors such as requirements imposed by EMTALA on hospital EDs, increases in the number of uninsured and in ED volume, and physicians' concerns over declining reimbursements generally have contributed to a breakdown in the traditional voluntary relationships between hospitals and physicians, often leading to physician demands for compensation for on-call coverage.

The two most common ways for hospitals to compensate physicians for coverage are either to pay the physician or group a fixed fee for providing coverage for a certain time period or to pay a fee for the services provided by the physician to each patient receiving care. These methodologies raise significant issues from both practical and compliance standpoints, including (1) how to set compensation at a fair market value for the services provided; (2) whether the physician has a right to retain patient fees collected for services rendered, since the hospital is paying the physician under the coverage agreement; (3) whether compensation to a physician for coverage, regardless of whether any medical services are rendered, constitutes illegal payment for referrals; and (4) whether the arrangement meets other regulatory requirements. In two advisory opinions, one issued earlier this year, the OIG has approved arrangements using each of these two payment methodologies and confirmed that, at least in certain circumstances, such arrangements can be entered into with limited or no regulatory risk.

**Advisory Opinion No. 09-05 – Payment for Services Furnished to the Uninsured.** In OIG Advisory Opinion No. 09-05, issued in May 2009, the OIG approved a proposed arrangement by which a hospital would compensate physicians for on-call services performed for the hospital's uninsured patients. As described in the advisory opinion, the hospital's bylaws required all members of its active medical staff to provide some on-call coverage for its Emergency Department and further care for patients referred to them while providing this coverage. However, physicians in certain medical specialties had reduced their ED coverage such that the hospital lacked the needed coverage in those specialties for several weeks each month.

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Under the proposed arrangement, the hospital would allow participating physicians to submit claims to the hospital for payment for services rendered to certain indigent and uninsured patients presenting to the hospital's ED. The hospital's patient accounting department would verify that the patients in question were not covered by any governmental or private insurance plan and would eventually qualify for a state program funding care for low-income patients. Participating physicians were required to be members of the hospital's medical staff, sign a letter of agreement that while on call they would respond within 30 minutes of receiving a request from the ED to consult on a patient, evaluate the patient in person, and provide additional evaluation and care as clinically indicated. The physicians had to follow the hospital's claim request process and waive any other billing or collection rights for the services they bill to the hospital. If the hospital determined that payment was available from another payor, the hospital would return the claim form to the physician's office for the physician to pursue payment. All participating physicians must provide on-call coverage at the ED as part of the organized on-call schedule for the physician's department or specialty, not to exceed one week of call per month. The hospital's bylaws would be amended to reflect the new on-call coverage policy.

The hospital's patient accounting department would pay the physician's claim if there was no other payor source and the patient met the eligibility requirements. Payment would be made based on services actually needed and provided, with fixed payment amounts within the range of fair market value for services rendered. The arrangement provided payment only for services provided while the physician was on call for the ED or for inpatient care provided to patients admitted while the physician was on call for the ED. The fixed fees assigned to certain services were as follows: $100 per patient for a face-to-face emergency consultation; $300 per admission for care of one of those patients who was admitted from the ED as an inpatient; $350 to the primary surgeon of record for a surgical procedure or procedures performed on one of those admitted patients; and $150 to a physician who performed an endoscopic procedure or procedures on such an admitted patient. Except as provided above, there would be no variation in payment by physician specialty.

The OIG found that although the proposed arrangement could potentially generate prohibited remuneration under the Medicare and Medicaid Anti-Kickback Statute, the OIG would not impose administrative sanctions. In evaluating the proposed arrangement, the OIG recognized that hospitals are increasingly compensating physicians for on-call coverage at the ED and have legitimate reasons for doing so, which may include compliance with EMTALA, a shortage of certain physicians, or limited access to trauma services for local patients. However, the OIG noted that payment for on-call coverage potentially creates the risk that hospitals might pay physicians to entice them to join or remain on the medical staff or to generate additional business for the hospital. Payments for on-call coverage may disguise unlawful remuneration (1) when they do not reflect bona fide lost income; (2) when no identifiable services are provided; (3) when payments are disproportionately high in the aggregate compared to the physician's regular medical practice income; or (4) when the physician is paid by the hospital for professional services furnished while on call but receives separate, additional reimbursement from insurers or patients.

The OIG found that the proposed arrangement would not meet the requirements of the safe harbor for personal services and management contracts, 42 C.F.R. § 1001.952(d), under the Anti-Kickback Statute because the aggregate compensation paid to the physician was not set in advance and would vary with the services provided. However, the OIG found that the proposed arrangement presented a low risk of fraud and abuse because of the following factors: (1) the arrangement provided for payment only for tangible services rendered by the physicians pursuant to their on-call duties, rather than any "lost opportunity" costs; (2) the payment would only be made for services rendered to uninsured patients, so there was little risk that the physician would be paid twice for the same service; (3) the physicians were required to provide follow-up inpatient care in the hospital to all patients seen in the ED, so physicians would be at risk for furnishing additional care without compensation; (4) the hospital had certified that the payment amounts were within the range of fair market value for services rendered, without regard to referrals or other business generated, and each payment category reflected the value of services actually provided and was uniform for all physician specialties; (5) the hospital had demonstrated the legitimate need for the arrangement, based on the medical staff's attitude toward on-call coverage and the hospital's resulting lack of coverage by needed specialists during some weeks; (6) the arrangement imposed other tangible responsibilities on the physicians, such as requiring responses within 30 minutes of the ED's request, evaluating the patient in person, and providing additional evaluation and care as appropriate; and (7) the hospital was required to provide this care to be eligible for funding under a state program for low-income patients.

Advisory Opinion No. 07-10 – Per Diem Payments for On-Call Coverage. While recent Advisory Opinion 09-05 approved hospital payments for physician services actually delivered to uninsured patients while on call, the OIG previously approved paying physicians a per diem rate for on-call coverage that exceeds the normal medical staff requirements, regardless of whether the physician renders any care. In OIG Advisory Opinion No. 07-10, issued in 2007, the OIG approved an arrangement for a hospital to pay a per diem rate for each day spent on call at the ED. The OIG noted that the tax-exempt, nonprofit hospital had a charitable mission to help the poor but was faced with physicians in certain medical specialties who were unwilling to provide without compensation either on-call coverage at the Emergency Department or uncompensated inpatient follow-up care for patients who initially presented at the ED. On the recommendation of an ad hoc committee evaluating the situation, the hospital had adopted an arrangement that offered to all physicians in certain specialties on the medical staff the opportunity to provide paid ED on-call coverage as assigned by their departments, respond to emergencies in the ED, and provide inpatient care to uninsured patients.

Under the plan that already had been put in place, participating physicians were paid a per diem rate for each day spent providing on-call coverage at the ED, except for the one-and-a-half days per month (or 18 days per year) each physician was required to provide gratis. In contrast to the limited, flat payments addressed in Advisory Opinion No. 09-05, here the per diem rate was calculated based on a number of factors varying by specialty, including the severity of illness typically encountered, the likelihood of having to respond, and the degree of inpatient care required for patients initially presenting at the ED. An independent consultant reviewed pay rates and practices at dozens of medical facilities, developed benchmarks for reasonable compensation, and issued an opinion as to the fair market value of the per diem rates.

Although the OIG approved the arrangement by indicating that it would not impose sanctions, the OIG found that the arrangement in Advisory Opinion 07-10 for compensating on-call coverage did not satisfy the personal services and management contracts safe harbor because the aggregate amount of compensation was not set in advance. The OIG cited the fact that monthly payments to physicians participating in the arrangement could fluctuate from month to month because the days of compensated call provided might vary.

How did the OIG justify approval of a flat per diem payment for on-call coverage regardless of the patient services actually rendered, in light of its position in the more recent Advisory Opinion No. 09-05? The OIG in opinion No. 07-10 noted that compensation might disguise illegal kickback payments if they represented "lost opportunity" payments that did not reflect bona fide lost income or if payments compensated physicians when no identifiable services had been provided. However, the OIG found that the arrangement presented a low risk of fraud because the hospital certified that payments were fair market value for actual services needed and provided, without regard to referrals or other business generated between the parties.

Specifically, the OIG found in Advisory Opinion 07-10 that the per diem rates were tailored to cover substantial, quantifiable services, a large portion of which were furnished to uninsured patients in the ED and after admission to the hospital. Payments were administered uniformly for all physicians in a given specialty, but unlike as required in Advisory Opinion 09-05, not across all participating specialties, without regard to a physician's referrals. Factors used to calculate the different per diem rates included (1) the physician specialty and whether coverage was on a weekday or weekend; (2) the extent

# OIG Methods...
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of the uncompensated responsibilities that would likely fall on each specialty; (3) the severity of illnesses typically encountered; (4) the likelihood the physicians would need to respond to a call from the ED and would need to provide on-call care to an uninsured patient; (5) the degree of inpatient care they typically provided patients admitted from the ED; and (6) the degree of inpatient care they typically provided. Presumably this detailed methodology for calculating the per diem rates for on-call coverage, based on the amount of actual services that would typically be provided by a physician on call in the same specialty, distinguished this arrangement from prohibited payments for "lost opportunities" or for no identifiable services, which have been condemned by the OIG.

Satisfying the Requirements of the Personal Services Safe Harbor. While these OIG advisory opinions provide guidance to the industry, they also warn that advisory opinions may not be relied upon by any person other than the party requesting the opinion. Therefore, another party that proceeds with an arrangement without first obtaining approval by the OIG through the advisory opinion process is taking some risk, at least in theory. The only other way to avoid this risk would be to construct a call coverage arrangement that conforms to every requirement of the safe harbor for personal services and management contracts.

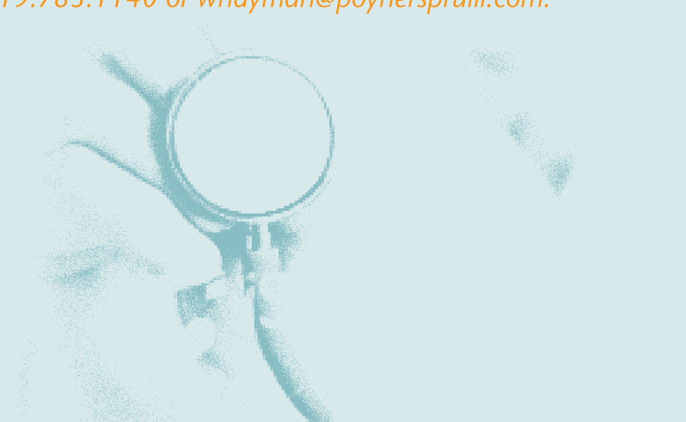
Aggregate Compensation Set in Advance. To meet the requirements of the safe harbor, the aggregate compensation over the term of the agreement must, among other things, be set in advance, be consistent with fair market value, and not be determined in a manner that takes into account the volume or value of any referrals or business generated between the parties. Although the aggregate compensation discussed in Advisory Opinion No. 07-10 was not set in advance, a similar methodology could be devised requiring each physician or group to provide call coverage for a set number of days during the entire year. The hospital then could calculate a fixed, aggregate payment to be paid monthly to the physician or group. As with the arrangement covered in Advisory Opinion No. 07-10, the physician would always run a risk that he or she would be inadequately compensated by such payments.

Specified Schedule of Intervals. The personal services safe harbor also requires that if the agreement is intended to provide services on a "periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement [must] specify exactly the schedule of such intervals, their precise length, and the exact charge for such intervals." This requirement was not mentioned by the OIG in either of the two advisory opinions, which may indicate it is of less concern to the government. A full-time call coverage arrangement would meet this test, but full-time coverage would be possible only if a hospital had only one group practice in a particular specialty on its staff or one group that was willing to take all the call coverage in that specialty. Otherwise, it would be possible, though challenging, to actually specify in the coverage agreement the schedule of the intervals (and the exact charge for each interval) of call coverage assigned to multiple physician groups.

In condemning compensation for physicians when no identifiable service has been provided, the OIG unfortunately ignores the fact that a physician who is providing call coverage furnishes a service merely by being available and limiting his activities so that he can respond in a timely fashion. The frequency with which the physician or others in his specialty are called; the severity of the illnesses treated; and the incidence of necessary, uncompensated follow-up care all would affect the reasonableness of the compensation. Any increased malpractice risk inherent in treating the uninsured, who often lack preventive care and regular physician contact, may also be relevant to such physician compensation.

These advisory opinions are a double-edged sword for hospitals – while hospitals must provide adequate physician call coverage, they are understandably reluctant to open "Pandora's box" by paying for call in some medical specialties but not in others. However, hospitals may no longer dismiss such arrangements out of hand based on legal concerns. Hospitals encountering difficulties in ensuring adequate on-call coverage may need to consider whether either type of payment arrangement described here could be used to meet their obligations.

*If you have any questions regarding this article or other health care law issues, please contact Wilson Hayman at 919.783.1140 or whayman@poynerspruill.com.*



# The Evolving Privacy Frontier

*by Pam Scott*

## *Final Breach Notification Rules Are Here*

### Breaches of Unsecured PHI

In late August, the Department of Health and Human Services published its interim final rule governing breach notifications required under the Health Information Technology for Economic and Clinical Health Act (HITECH), a component of the American Recovery and Reinvestment Act of 2009 (ARRA). The new breach notification rule implements the HITECH requirement that hospitals and other HIPAA-covered entities and their business associates must promptly notify individuals if and when the privacy of their unsecured personal health information (PHI) is breached. Unsecured PHI is any PHI that is not secured through a technology or methodology specified by HHS. The rule clarifies that the privacy and security of PHI is compromised and the notification requirement is triggered only if the acquisition, access, use, or disclosure of the information poses a significant risk of financial, reputational, or other harm to the individual. In this era of heightened privacy concerns, hospitals and other covered entities would be wise to consider adopting a conservative approach to this risk assessment.

Consistent with HITECH, the final rule includes the following exceptions where the breach notification requirement is not triggered: (1) unintentional acquisition, access, or use of PHI by an employee or individual acting on behalf of a covered entity or business associate, if the PHI was acquired, accessed, or used in good faith and within the scope of employment or other professional relationship and was not further accessed, used, or disclosed in a manner not permitted under the HIPAA Privacy Rule; (2) an inadvertent disclosure occurs by an individual authorized to access PHI at a covered entity or business associate to another individual authorized to access PHI at the same covered entity or business associate, provided the PHI is not further accessed, used, or disclosed in a manner not permitted under the HIPAA Privacy Rule; or (3) a good-faith belief by a covered entity or business associate that the unauthorized person to whom the disclosure of PHI was made would not reasonably have been able to retain the information.

When a breach occurs, the final rule requires notifications to be made without unreasonable delay, but in any event within 60 calendar days after discovery of the breach. If the breach involves 500 or more individuals, the covered entity must also inform HHS and prominent media outlets serving the area in question. For breaches involving fewer than 500 individuals, a covered entity may maintain a log of such breaches and provide an annual report of such breaches to HHS.

Under the final rule, the requirements for providing notice include:

- Notification written in plain language;
- A brief description of what happened, including the date of the breach and the date of the discovery of the breach if known;
- A description of the types of unsecured PHI involved in the breach;
- Steps individuals should take to protect themselves from potential harm resulting from the breach;
- A brief description of the action the covered entity or business associate is taking to investigate and mitigate harm; and
- Contact procedures for affected individuals with questions or concerns. Contact information must include a toll-free number, e-mail address, website URL, or postal address.

# Evolving...
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In addition to clarifying the parameters of the breach notification requirement, the final rule updates HHS guidance specifying technologies and methodologies for securing PHI that would provide a safe harbor from HITECH's breach notice obligations for HIPAA-covered entities and business associates that adopt them. The rule affirms that the only method to render electronic PHI unusable, unreadable, or undecipherable to unauthorized persons is through encryption. With regard to information in nonelectronic formats, those records must be destroyed in order to meet the safe harbor requirements for avoiding the breach notification.

The HHS breach notification rule goes into effect September 23, 2009. While HHS is urging covered entities and business associates to promptly comply, the department also recognizes that doing so may take some time. Accordingly, HHS has indicated it will not enforce the rule for breaches that are discovered before February 2010.

## Breaches of Other Personal Electronic Health Information

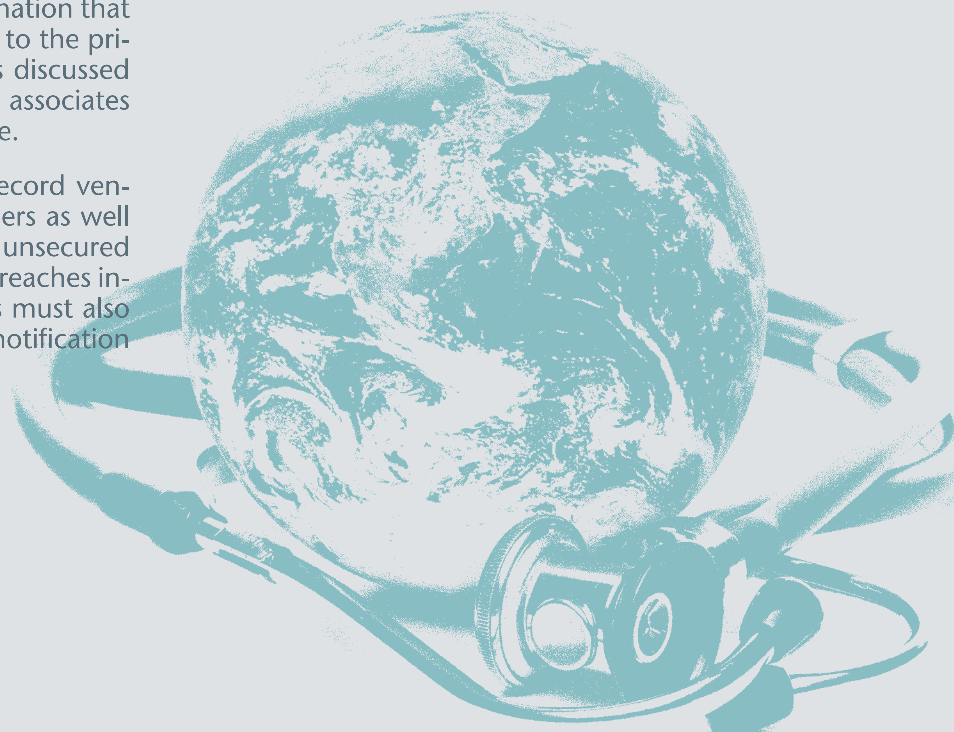
Also in mid-August, the Federal Trade Commission issued a companion final rule requiring certain Web-based businesses to notify consumers when the security of their electronic health information is breached. The FTC breach notification rule, which was required by Congress under ARRA, applies to both vendors of personal health records that provide online repositories that people can use to keep track of their health information and entities that offer third-party applications of personal health records. It is intended to help protect the privacy and security of individuals' electronic health information that is in the hands of entities that are not subject to the privacy and security requirements of HIPAA. As discussed above, HIPAA-covered entities and business associates are subject to the HHS breach notification rule.

Under the FTC's final rule, personal health record vendors and related entities must notify consumers as well as the FTC of a breach involving consumers' unsecured electronic health information. In the case of breaches involving 500 or more people, affected entities must also notify the media. Similar to the HHS breach notification rule, the FTC rule does not apply to health information that is secured through technologies specified by HHS. The FTC is set to begin enforcement of its breach notification rule in February 2010.

## Who is your regional privacy advisor?

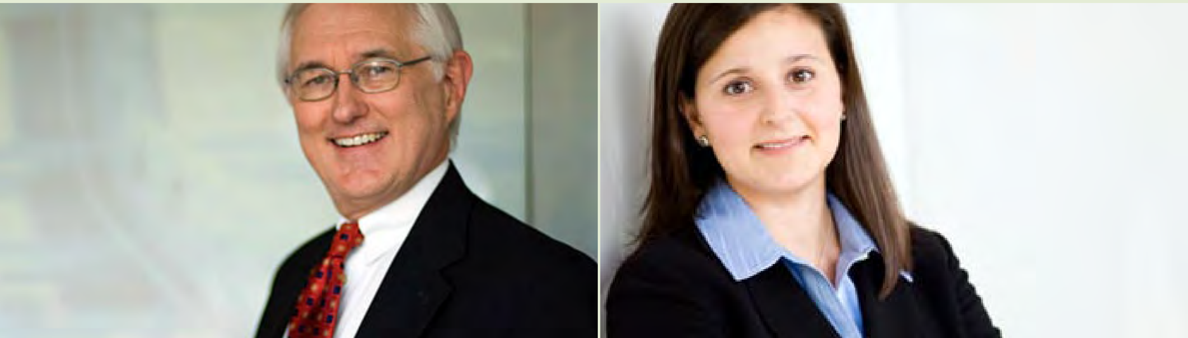
Hospitals and other health care providers now have a regional privacy advisor within the Office of Civil Rights. In mid-August, HHS appointed the managers of each regional OCR office to also serve as the regional privacy advisors. Now that we know who these regional privacy advisors are, the real question is what will they be doing? These regional advisors, required by HITECH, are supposed to provide education and guidance to hospitals and other covered entities and their business associates aimed at helping them comply with HIPAA privacy and security requirements. Because these are new positions, it is not yet clear whether the guidance offered by these regional privacy advisors will come in the form of informal FAQs, written advisory opinions similar to those provided by the OIG, or some other format. Time will tell.

*If you have any questions regarding HITECH or other health care law related issues, please contact Pam Scott at 919.783.2954 or pscott@poynerspruill.com.*



# Disruptive Physicians

*by Steve Shaber & Jessica M. Lewis*



Just over a year ago, in July 2008, the Joint Commission (JC) issued two standards that address disruptive behavior, a leadership standard (LD.03.01.01) and a medical staff standard (formerly MS.4.00, now MS.06.01.03). These standards went into effect January 1 of this year, requiring JC-accredited hospitals and other health care institutions to develop a code of conduct that defines acceptable, inappropriate, and disruptive physician behavior and the process for addressing such behavior. These standards obviously aim to ensure that quality of care is not compromised, so the goal should not be to punish but to deter and address disruptive behavior so that a physician may return to a safe and productive practice.

The JC medical staff standard lists general competencies expected of physicians undergoing the credentialing and privileging process and adds two behavior-relevant competencies: Interpersonal and Communication Skills, and Professionalism. (See Introduction to Standard MS.06.01.03.) The JC standard for leadership sets forth ten "Elements of Performance" under LD.03.01.01 that the JC believes will help leaders foster a "culture of safety and quality" in their institutions. These elements are broad – it is up to the institution to determine how to accomplish these objectives. Generally, the elements require hospital leadership to regularly evaluate its hospital's "culture of safety," to identify and implement needed changes, and to foster open discussion of safety and quality issues. Specifically, two of the elements require the hospital to implement a code of conduct that defines acceptable, disruptive, and inappropriate behaviors, and to implement a process for managing disruptive and inappropriate behaviors. (See LD.03.01.01, Elements of Performance 4 and 5.) The LD standard provides no example code of conduct or evaluation/discipline process.

In response to the JC standards, the AMA issued its own Model Medical Staff Code of Conduct (the Model Code) in March of this year, and it called for these codes to be incorporated into hospital medical staff bylaws, where they will always have the greatest dignity and where, in most states (including North Carolina), they will have the force of contracts. In its Model Code, the AMA was concerned, among other things, about defining disruptive behavior too broadly and about being sure to provide adequate due process provisions. To expand on and clarify the JC standards, the AMA's Model Code incorporated specific examples of appropriate, inappropriate, and disruptive behaviors and provided a comparatively detailed procedure for addressing the latter.

Appropriate behaviors under the AMA Model Code include:

+ Good-faith criticism communicated to improve quality of care;
+ Encouraging clear communication;
+ Expressions of concern about a patient's care and safety;
+ Expressions of concern about hospital policies;
+ Constructive criticism;
+ Comments to leadership regarding patient care by others;
+ Participating in medical staff/hospital meetings;
+ Membership on other medical staffs; and
+ Seeking legal advice or initiating legal action for cause.

All these behaviors must be carried out in a respectful, appropriate, reasonable, and professional manner. The AMA clearly wants to encourage and protect doctors' words and deeds that are intended to protect their patients and their profession while, at the same time, reminding all physicians to act appropriately and professionally when they seek to protect their patients and their

profession. Under the AMA Model Code, once it is determined the conduct is appropriate, it cannot be punished.

The AMA Model Code distinguishes between inappropriate and disruptive behaviors, with the former being unwarranted behaviors that reasonable people would see as offensive and the latter being those abusive behaviors that rise to the level of risking harm to a patient or to quality of care. The Model Code discourages and provides for the correction of inappropriate behaviors, while it prohibits and provides for the punishment of disruptive behaviors.

Inappropriate behaviors under the Model Code include, but are not limited to:

+ Making belittling, personally sarcastic, or condescending statements;
+ Name-calling;
+ Using profanity;
+ "Blatantly" failing to respond to patient care needs or staff requests; and
+ "Deliberately" failing to return calls, pages, and messages.

Disruptive behaviors include, but are not limited to:

+ Physically threatening anyone in the hospital;
+ Making threatening or intimidating physical contact with another person;
+ Throwing things;
+ Threatening violence or retribution;
+ Sexual and other harassment; and
+ Persistent inappropriate behavior, rising to the level of harassment.

The Model Code's distinction between types of misconduct and its levels of discipline, as noted below, seem to draw a distinction between the type of conduct that a hospital must address but which should not be grounds for suspension or other formal "corrective action" against a physician's clinical privileges and conduct which should be grounds for "corrective action." In keeping with the AMA's apparent goal of addressing some lesser misconduct without immediately and unnecessarily submitting physicians and committing hospital resources to corrective action and the fair hearing process, the Model Code's procedures for handling inappropriate and disruptive physician behavior include the following:

- Medical staff bylaws and their protections are applicable throughout the procedures described by the Model Code, including the right of the physician to be represented by an attorney at each stage of the proceedings.
- Reporting may not be anonymous. Any complaint must be made in writing and signed by the complainant. However, no physician may retaliate against a complainant and retaliation is itself grounds for corrective action, even if the original complaint was not.
- A copy of the complaint must be provided to the physician, who may then respond in writing to the allegations.
- An ad hoc committee, consisting of one medical staff officer and two or more elected members of the medical executive committee (one of which must be the accused physician's department head), must investigate the allegations to determine whether they are legitimate and how serious they are.
- Discipline for inappropriate behavior depends on how many times the physician has been accused. A first offense requires informal counseling of the accused physician by the department head. A second offense, unless it manifests a persistent course of inappropriate conduct, requires sending a notification to the physician of the conduct expected of him or her. Continued or persistent offenses may amount to harassment requiring a rehabilitative action plan, and if it proves unsuccessful, a final warning letter indicating that suspension or termination proceedings may ensue in accordance with the provisions of the medical staff bylaws. Records of these types of actions are to be kept confidential, in a file separate from the physician's credentialing file.
- Four types of misconduct can lead to corrective action, a fair hearing, and loss of privileges or staff membership. The first two are (i) repeated disruptive behavior and (ii) repeated inappropriate behavior that rises to the level of repeated harassment (which is, of course, a kind of disruptive behavior).
- The third kind of misconduct that leads to a fair hearing is a summary suspension (in accordance with the medical staff bylaws) for a single incidence of disruptive behavior that constitutes "an imminent danger to the health of an individual."
- The fourth kind of misconduct that leads to corrective action is, as mentioned above, retaliation.
- If the behavior may be due to illness or impairment, confidential investigation and evaluation per the provisions of the medical staff bylaws may be most appropriate. Such evaluation is available in North Carolina through the Physicians Health Program. Hospitals should note that the Americans with Disabilities Act might provide a basis for a disgruntled physician whose behavior is triggered by, for example, a substance abuse problem to take legal action against the hospital for alleged unfair treatment. Thus, it is im-

portant to investigate the allegations and to involve appropriate professionals to assist with handling of behavior related to substance abuse or mental health impairments.

Any hospital should also keep in mind the provisions of the Health Care Quality Improvement Act (HCQIA), which, if met by the hospital, afford the hospital qualified immunity from monetary damages in a lawsuit by the disciplined physician. When a hospital takes action against a physician, the hospital must:

- Reasonably believe that the action is in furtherance of quality care;
- Make reasonable efforts to obtain the facts of the matter;
- Provide adequate notice and hearing procedures for the physician (or other such procedures as are fair under the circumstances); and
- After an investigation and hearing, reasonably believe that any action taken against the physician was justified by the facts.

HCQIA has been in effect for many years, and by now all staff bylaws or fair hearing plans ought to meet its requirements, but there are elements of intent in the law, and actual ill will or unreasonable conduct will leave the parties open to suit.

So what should your hospital's code of conduct and procedures for addressing inappropriate and/or disruptive behavior look like? First, keep in mind that the code of conduct and related procedures are hospital policies that must be in line with JC standards but also must be designed to achieve fairness for the institution and the physician. Some key elements of any such policy include:

- **Definitions:** Your policy should define behaviors that may constitute disruptive conduct by a medical staff member. The AMA Model Code would be a useful starting place, but every medical staff and every hospital need to meet their own needs.
- **Complaint Process:** Your policy should detail procedures for reporting disruptive behavior, including requirements for the content of the report, to whom to report, and whether the report may be anonymous. Some facilities use hotlines for anonymous reporting, though the AMA Model Code advocates against anonymous reporting. The JC standards are silent on this issue.
- **Investigative Procedures:** Every complaint should be evaluated, and your policy should define who is responsible for conducting the evaluation and investigation, how the investigation will be carried out, and to some extent what parameters will be used in conducting the investigation so as to guarantee it is a reasonable investigation. Generally, this process should be in line with that of your medical staff bylaws' process for investigating other misconduct by physicians.
- **Due Process Procedures:** Medical staff bylaws invariably define the grounds that would support corrective action that might lead to a loss of medical staff membership or clinical privileges and those that would not. A distinction between inappropriate and disruptive conduct that may or may not lead to corrective action requires carefully written bylaws that clearly state what conduct leads to corrective action and when.
- **Disposition of the Complaint:** Your policy should set forth the possible outcomes once a complaint is initiated. For example, if the complaint is investigated and unsubstantiated, it will be dismissed. A record of the complaint and the investigation will be maintained outside of the physician's credentialing file. If the complaint is investigated and substantiated and a hearing is held, the following sanctions may be issued: reprimand, mandatory participation in a rehabilitation program, suspension, and so forth. It should be noted that unprofessional conduct that could have affected or actually did adversely affect a patient and that resulted in a suspension or other adverse action against the physician's clinical privileges lasting more than 30 days must be reported to the National Practitioner Data Bank.

Once a policy or code of conduct is in place, it is imperative that the hospital educate its medical staff and other personnel on the policy in order to provide proper notice to the physicians it may affect and to deter inappropriate and disruptive behaviors. Grounds for physician discipline should always appear in the medical staff bylaws, so best practice dictates making your hospital's code of physician conduct and related fair hearing plan part of your medical staff bylaws.

*For more information on this article or health care law issues, you may contact Jessica Lewis at 919.783.2941 or llewis@poynerspruill.com or Steve Shaber at 919.783.2906 or sshaber@poynerspruill.com.*

# House Bill 1135 Adds Substantially to North Carolina's Health Care Enforcement Arsenal

*by Chris Brewer*

By enacting House Bill 1135 during its 2009 legislative session, the North Carolina General Assembly adopted a new State False Claims Act, which substantially expands the state's arsenal for criminal and civil prosecution and recovery in health care and other cases. The act was passed in the wake of the federal Deficit Reduction Act of 2005, which allows states with a false claims act certified by the Office of Inspector General for the U.S. Department of Health and Human Services to be as effective as the federal law in allowing the state to retain an additional 10 percent of the federal share of Medicaid funds recovered.

The principal elements of the new act provide that:

- Effective August 28, 2009, the act authorizes the attorney general to use a document subpoena known as a "health care fraud subpoena" to obtain documents and materials from corporations and government entities relevant to a criminal investigation of a violation of N.C. Gen. Stat. § 108A-63.
- Effective December 1, 2009, the act creates an additional legal basis for criminal liability under the existing Medical Assistance Provider Fraud statute and adds a new obstruction of justice offense.
- Effective January 1, 2010, the act authorizes a private person, known as a "qui tam plaintiff," to bring an action as a whistle-blower on behalf of the state, where the person has information that the defendant or defendants have knowingly submitted or caused the submission of false or fraudulent claims to the state. The qui tam plaintiff may be awarded an amount between 15 and 25 percent of the amount of any recovery, which is paid from the proceeds of the action or settlement.

*For more information on this article or health care law issues, you may contact Chris Brewer at cbrewer@poyners.com or 919.783.2891.*

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