Hospital Compliance Frequently Asked Questions

1. Do Hand-Held Computers bring HIPAA Risks?

Q: Increasingly our physicians are using their personal digital assistants (PDAs) to download patient records to take home or work on after hours. Should I be concerned about these practices from a HIPAA perspective?

A: As more and more health care providers use PDAs or handheld computers to store their appointments, patient information, and prescription data, the likelihood of security threats increases. Many providers "synch-up" their PDAs with their appointment schedule and may download information from home to a central server. PDAs are notoriously insecure as few of them have any built-in security features.

If you have providers using PDAs to store protected health information, you need to add password authentication at a minimum. In addition, a number of technology vendors are providing PDA add-ons, which provide stronger authentication such as digital signature or fingerprint recognition. In the meantime, I recommend the following procedures for securing handhelds:

- Apply encryption to handhelds
- Use secure sockets layer (SSL) encryption for data transported over the Internet
- Require an automatic screen saver for handhelds
- Develop a policy on the use of handhelds to store patient data

Go to http://www.medicalwizards.com/ for details on mobile computing and security products.

2. What should we do about a "nosy" physician?

Q: We have a physician, Dr. A, on staff who is "nosy" and is constantly reading the charts of other physicians' patients. He recently made a remark to another physician about a prescribing decision for a patient. He evidently pulled the chart at random because he wondered about that physician's competency. We have asked him to stop "peeking" at other physician's charts, but he says that he has not broken any laws and our by-laws do not forbid "peeking." We are very concerned with the legality of what he is doing. What laws, if any, has he violated?

A: Dr. A is not the problem, nor has he ever been the problem. He has not violated any laws and he will not be violating any provisions of the Health Insurance Portability and Accountability Act (HIPAA) unless it can be proven that he used the information for untoward purposes. The problem is with the leadership of the medical staff and the provisions for maintaining privileges specified in the by-laws. If you want discipline, you have to structure the privileging process to provide a basis for discipline. Dr. A's privileges should be contingent on his agreement to only seek patient health information on a "need to know" basis. If it is subsequently learned that Dr. A violated the privilege agreement, he should be disciplined.

One of the important issues with health care information system design has to do with access philosophy. Many hospitals structure access so that physicians can get information only about their own patients. Referral physicians must be identified by the assigned general practitioner (GP) or specialist to gain access. However, this creates a problem when the assigned GP or specialist does not identify the referral physician in a timely fashion. Another philosophy is to open the information system to all physicians with privileges and to place them under the strictures of professional behavior as defined by the medical staff by-laws.

The question was answered by William R. O'Rourke, Jr., vice president of Strategic Management Systems, Inc. of Alexandria, VA. The company provides consultant <services for corporate compliance and HIPAA administrative simplification.

3. Does EMTALA apply in non-clinical setting?

Q: The Emergency Medical Treatment and Active Labor Act (EMTALA) seems confusing when it comes to the expanded definition of hospital property. If a patient needs emergency treatment and presents him- or herself to a non-clinical employee in a non-clinical area, what is the appropriate response? For example, what should be done if a patient walks into our finance department, what is a separate building 100 yards from the emergency department, or a patient drives to the hospital and collapses in the middle of the parking lot and is discovered by a nutrition services person? Do we bring medical staff to the patient, even though it is significantly outside our clinical structure?

A: Historically, the Office of Inspector General (OIG) has taken the position that a patient who comes onto hospital property is covered by the EMTALA statute, not with standing language that states the statue's applicability to any individual who "comes to the emergency department." The new regulations have merely cemented the OIG's view in this area, by expanding and elaborating upon this definition to include basically the entire hospital campus. These regulations make it clear that the OIG will be looking for potential EMTALA

violations in situations where individuals arrive on hospital property with an emergency medical condition, even when they do not present themselves to the hospital's emergency department.

The new regulations also in some respects redefine the obligations of off-campus departments that are staffed by physicians, registered nurses (RNs), or licensed practical nurse (LPNs). All off campus departments staffed with these types of health care professionals are required to adhere to specific-protocols for handling emergency medical conditions and to designate a health care professional at the off campus site to initiate an appropriate medical screening of the patient under EMTALA. The regulations mandate direct contact between off-campus personnel and emergency personnel at the main hospital campus.

For off-campus departments that are not routinely staffed with physicians, RNs, or LPNs, the regulations require that the hospital give the department's employees protocols to contact emergency personnel at the main hospital campus for direction. These obligations include disclosing the patient's symptoms, appearance, and overall condition to emergency personnel at the main campus. If necessary, the employee must arrange for transportation to the main campus for an appropriate screening or treatment, assuming the main campus has the capability of dealing with the patient's medical condition. If the patient is unstable, investigators will likely view the transfer of the patient to another hospital as at least a technical violation of the statue unless there is a specific medical reason for the transfer and the transferring physician certifies that the benefits of the transfer outweigh the risks.

There is a risk that any denial of treatment or failure to respond to a situation in accordance with the hospital's EMTALA obligations will be deemed as a violation of the statue. Hospitals should also be concerned with private EMTALA actions that may result from these situations. Put a mechanism in place to ensure that the hospital complies with all of its obligations under EMTALA, regardless of the location on the campus where the patient initially presents.

This question was answered by Joseph T. Gatewood, an associate in the Health Care Group at Arent Fox, formerly an associate counsel with the Office of Counsel to the Inspector General.

4. Which records should we send to other doctors?

Q: We are a large practice, and we're constantly receiving requests for records from other doctors. We don't know whether to send the full chart or just recent visits. What should we do about collection notes in the chart? Also, do we bill the other doctor or the patient?

A: Generally, records are sent from physician to physician as a courtesy, with no billing to the other provider or the patient. In fact, many physicians just dictate a narrative summary to send. Wherever you send records, you need to have a valid signed release from the patient authorizing you to do this.

In this scenario, if there is a bill to present, the patient is responsible for the bill. Most importantly, your office needs to understand that collection information, insurance from copies, and collection notes do not belong in the clinical record and should be separated before the chart is mailed. All collection information should be kept separate from all patient

clinical notes. You would never want to prejudice a patient's future care with another provider if the collection notes sent indicate that the patient is a poor financial risk.

This question was answered by Mary Sue Jacka, president of Medical Management Consultants, Inc.

5. Can 'Kicking Back' with vendors bring Anti-Kickback charges?

Q: Our laboratory recently bought a new instrument and vendor wants to take the managers to a celebratory dinner. Would this violate the anti-kickback statue?

A: Possibly. The federal anti-kickback statute makes it a crime (and a civil violation of law) for any person knowingly and willfully to offer, solicit, pay or receive anything of value, in cash or in kind, directly or indirectly, to reward or induce a referral or to arrange for an item or service payable under a federally funded health care program. State anti-kickback laws are usually similar, though they normally apply to all payers, not just the federal programs.

Answer the following questions: What is the intent behind this celebratory dinner? Is it intended at any level to reward or induce the purchase? Although the value of the meal is technically irrelevant to whether or not there is a violation of the statue, the relative risk of enforcement action is a function of how expensive the meal is. In other words, if the dinner is at a five-star restaurant with a couple of $1,000 bottles of wine on the table, there is clearly more risk than a simple meal at the neighborhood Italian restaurant with $10 pasta platters.

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6. Will 'Clustering' tie Compliance efforts in knots?

Q: I've heard about "clustering." What is it and does it present any risks?

A: Clustering occurs when a physician practice only codes or charges one or two middle level codes (99202-99203 and 99212-99213). Some providers feel this approach will reduce errors and, in the end, everything will even out. Clustering is wrong: it will result in overcharging some patients, while undercharging other. Billings should be based on what is actually provided. Encounter forms should list all five levels of evaluation and management services, and the provider or coder should choose the correct code based on the services rendered.

This question was answered by Debbie Troklus, manager at PricewaterhouseCoopers in Louisville, KY..

7. Can an on-call physician send patients to the ER?

Q: Is it a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) for an on-call physician to send an inpatient to the emergency room (ER) for treatment, rather than come to the hospital when called?

A: The EMTALA statue is triggered by the obligation of both the hospital and the physician to provide an appropriate medical screening examination of the patient. The OIG takes the position that this applies to inpatients as well. Additionally, if the screening determines the presence of an emergency medical condition, the obligation is to stabilize and treat the patient within the capabilities of the hospital, or to conduct an appropriate transfer, as defied by the statutory criteria.

The hospital may be hit with a civil monetary penalty of up to $50,000 if it negligently violates one of the statutory requirements. The physician responsible for the examination, treatment, or transfer of the patient, including the on-call physician, who negligently violates a requirement, may also incur a civil monetary penalty of up to $50,000.

As noted above, there is a specific provision of EMTALA that applies to on-call physicians who fail to fulfill their on-call obligations. This provision could be applied to a physician who simply transfers his or her patients to the ER for the physician's convenience. Such transfers could be viewed as the on-call physician's refusal to provide a medical screening under EMTALA. The physician could also be deemed to have refused to provide an appropriate medical screening under EMTALA's general provisions, independent of whether he or she was on call. Willful or repeated failure to screen or treat patients could be deemed a gross or flagrant violation, which could result in the physician's exclusion.

However, if the physician sends the patient to the ER because he or she believes the move is in the best interest of the patient, it may be a legitimate medical decision. In such cases, although there may be a technical violation of the statute, the repercussions would be much less.

Physicians who fail to fulfill their obligations to perform screenings should be aware that they could come under scrutiny. Investigators who may inquire into these situations could legitimately question whether sending the patient to the ER was a proper exercise of medical discretion, or simply an effort to avoid screening the patient. The failure to screen the patient could be even more problematic if it violates hospital policy or if it occurs repeatedly.

This question was answered by Joseph T. Gatewood, an associate in the Health Care Group at Arent Fox, formerly an associate counsel with the Office of Counsel to the Inspector General.

8. Use caution with requests for patient information?

Q: "Can you tell me my friend John Dow's condition and where he's staying?

A: It may seem like a pretty harmless question, but you have no way of knowing whether the person asking is really a friend or what he or she plans on doing with the information. Be

careful: What you tell people about a patient could violate the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA).

9. Are Corporate Compliance and HIPAA Compliance the same thing?

Q: How does corporate compliance differ from HIPAA compliance and who is required to comply with corporate compliance as well as HIPAA compliance?

A: Corporate compliance is a generic term that refers to compliance issues that a corporate entity would have to contend with given its industry focus. In a health care context, corporate compliance usually involves a wide array of issues from billing and coding, to anti-kickback and self-referral, to licensure, Occupational Safety & Health Administration (OSHA) rules, antitrust prohibitions, and many others. With the compliance deadline for HIPAA on April 14, 2003, the term corporate compliance, when applied in a health care context, will include compliance with the HIPAA privacy standards.

The government has long encouraged health care providers to voluntarily enter into compliance programs designed to reduce health care fraud and abuse. The Office of Inspector General has issued a series of model compliance plans for different types of health care providers, but the HIPAA privacy standards create a separate compliance program requirement. Unlike voluntary corporate compliance programs, the HIPAA compliance plan requirements are mandatory for entities covered by the standards. Covered entities include health care payers, clearinghouses (including billing companies), and providers. Though there are many important similarities between the government's guidance on voluntary corporate compliance plans and the HIPAA compliance plan, there are significant differences as well.

This question was answered by William Sarraille, Esq., a health care attorney with Arent Fox in Washington, DC.

10. Can vendors donate prize money?

Q: Our hospital holds an annual golf tournament to raise funds for capital improvements. Each year, we ask current vendors for donations to use as prize money for the participants and for the awards banquet. We do not base our use of the vendor upon their response. Is this a compliance violation?

A: This situation is quite common, but it comes with some compliance risks. The anti-kickback statute makes it a violation of law for any person to offer, solicit, pay or receive anything of value, in cash or in kind, directly or indirectly, to reward or induce any order or to arrange for any service or item reimbursable under a federally funded health care program, if they act knowingly and willfully.

Although the government might wonder why "current vendors" are the only ones targeted for donations, your statement that the hospital does not base its buying decisions on the donations suggests that the necessary element of a prohibited intent is not present. Some hospitals and vendors take a conservative approach and refrain from solicitations or

donations. Others screen anyone involved in procurement from involvement with solicitations and donations, undertaking them on a "blind" basis. Others limit the amount of any solicitation request or donation.

This question was answered by William Sarraille, Esq., a health care attorney with Arent Fox in Washington, DC.

11. Can Residents dictate operating reports?

Q: Can resident physicians dictate operating reports? Our attending surgeon is listed as the surgeon and the resident is listed as the assistant. No charges are being submitted for the residents' services at the surgery.

A: There is no problem with a resident dictating an operative report that is signed by the attending surgeon as long as the operative report dictated by the resident describes the procedures performed by and findings of the attending surgeon. For billing purposes, residents' services during surgical procedures are not reimbursable by Medicare because these services are not considered "physician services." See 42CFR§405.522. Only the attending surgeon's services are reimbursable by Medicare.

There is no regulation requiring the attending surgeon to physically document the services rendered or findings of a surgical procedure. Residents can prepare the documentation for the attending surgeon, at his or her direction, but the attending surgeon needs to review, approve, and sign the dictated operative report, thereby validating that all of the information provided by the resident is accurate and complete.

This question was answered by Robert A. Wade, Esq., the general counsel and organizational integrity officer for Saint Joseph Regional Medical Center in South Bend, Indiana.