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NATIONAL PRACTITIONER DATA BANK

By Grant W. Peters

Congress created the National Practitioner Data Bank ("NPDB") in the Health Care Quality Improvement Act of 1986 (the "HCQIA"). The NPDB is maintained by the United States Department of Health & Human Services. The NPDB was intended, among other things, to restrict the ability of incompetent and unprofessional physicians to move between states without disclosure or discovery of their previous record of "adverse actions" by hospitals and other entities. Reportable adverse actions include: (1) loss or suspension of a license; (2) loss or suspension of clinical privileges; (3) loss or suspension of professional society memberships; (4) actions that adversely affect the clinical privileges of a physician for more than 30 days; and also (5) payment of medical malpractice claims.

The NPDB provides a system for nationally tracking physicians who are identified as having been subject to an adverse action. Health care entities are required to report all adverse actions taken against health care providers within 15 days from the date the action was taken. Not all facilities may be in compliance, however. Some reports suggest that reporting requirements to the NPDB have been ignored in order to avoid potential litigation from physicians contesting the report. Numerous hospitals and HMOs have not reported any adverse actions taken against physicians to the NPDB.

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Grant W. Peters, M.D., J.D.



Over 20 Years in Health Care Profession

Grant W. Peters, M.D., J.D. is a graduate of Loma Linda University where he received his degree in Chemistry and his M.D. He earned his juris doctorate at Boalt Hall School of Law, University of California, Berkeley. He also holds an M.S.A. in Healthcare Administration.

His legal practice at Borton Petrini LLP has been enhanced by his hands-on experience in the medical field. Grant has worked as an Associate Hospital Administrator for Professional Services; Chairman of the Department of Anesthesiology; Board of Directors/Governing Body Member; and President of a specialty physician group.

To stay abreast of the ever-changing legal field, Grant is a member of the Health Law Section of the American Bar Association and a Fellow of the American College of Legal Medicine.

Grant is available to provide legal services related to health care law.

NEW FEDERAL QUI TAM REQUIREMENTS

By Grant W. Peters

Beginning in January 2007, any organization that receives or makes annual Medicaid payments of more than \$5 million dollars must inform its employees and those of its agents and contractors of its compliance plan for detecting and preventing fraud and abuse, as well as informing those individuals of the federal and state false claims acts and the rights afforded to whistle-blowers under those acts. Covered entities are now required to tell their employees how to blow the whistle.

Individuals who first bring specified activities or practices of covered entities to the attention of the government may be entitled to receive part of the amount recovered by the government. This process is referred to as qui tam, which is an abbreviation for the Latin phrase referring to someone who sues on behalf of the King, as well as for himself.

The new regulations were part of the Deficit Reduction Act of 2005 ("DRA"), which was signed by the President in February 2006. The relevant DRA provision is entitled "Employee Education About False Claims Recovery" and amends the Medicaid requirements in the Social Security Act. Specifically, the amendment states that a covered entity must:

- (1) establish written policies to provide information about federal and state qui tam provisions, available remedies and whistle-blower protections;
- (2) include, as part of the written policies, the covered entities' procedures for detecting fraud, waste and abuse; and
- (3) include in any employee handbook a specific discussion of the applicable false claims laws, the rights of whistle-blowers and the employer's policies and procedures for detecting and preventing fraud, waste and abuse.

California has its own qui tam regulations in the California Government Code. These are applicable in addition to the federal qui tam regulations, discussed above. Under California law, the penalties for a violation of the State False Claims Act include treble damages and a fine of up to \$10,000 for each false claim.

The challenge to covered entities will be to inform employees of the statutorily required information in a way that does not encourage frivolous reporting of claims of fraud. One approach, in addition to adding the information to the employee handbook for new hires, is to provide all employees a memorandum from a senior executive or corporate compliance officer. If questions arise subsequently, it may be helpful to have an information seminar addressing the topics.

Providers should keep in mind that the new requirements are a condition of receiving federal payments, including Medi-Cal payments, and failure to comply could potentially give rise to a claim for a violation of the False Claims Act. The potential liability can be relatively easily avoided by providing the necessary information, as outlined in the DRA.



Dee H. Stasopolis

20 Years Experience in Health Care Law



Dee H. Stasopolis is a Partner in the Bakersfield office of Borton Petrini, LLP. Dee graduated from Southwestern School of Law in 1982. In addition to his admittance to the State Bar of California, he is admitted to practice before the U.S. Supreme Court, the Ninth Circuit Court of Appeals and all Federal District Courts for the State of California.

His areas of specialty at Borton Petrini, LLP involve commercial health care litigation, health care law, and medical malpractice.

Dee is a member of the Kern County Bar Association, as well as the State Bar of California. His professional involvement also has included instructing insurance companies on settlement tactics, conducted legal-liability assessments for companies and has served as an arbitrator for the Los Angeles and Kern County Superior Courts. Dee has handled numerous cases involving medical malpractice, commercial health care disputes and other medical compliance issues. He is also a member of the DRI Section on Health Care Law.

***False Claims Act
Restrains Noncompliance***

by Grant W. Peters

Information in the NPDB is intended to be confidential with limited release. Information may be released to: (1) hospitals and other health care entities where a physician has applied or reapplied for staff privileges; (2) state licensing boards; and (3) a medical malpractice plaintiff asserting a claim against a hospital that failed to request information from the NPDB on a particular physician. In the latter case, the information may be used only for the claim against the hospital.

In order to encourage the required reports, the act limits the liability of the reporter. As long as the report is not knowingly false, there can be no liability for making the report. Courts have recognized that immunity is available whenever a health care entity accurately reports the adverse action that it took. Whether or not the adverse action was valid or justified is irrelevant for the purpose of immunity.

In one recent case, a plaintiff physician brought suit against a hospital after the hospital terminated his staff privileges. The plaintiff's claims included a cause of action for defamation based upon the hospital's report of the adverse action to the NPDB. The plaintiff's defamation claim was dismissed. The dismissal was subsequently upheld by the State Supreme Court, which noted that the hospital was immune under the HCQIA, so long as it did not know that the report it was making was false.

In another case, a physician sued the hospital for, among other things, reporting that it had not renewed his medical staff privileges. The court noted that "regardless of whether the hospital followed the letter of its bylaws in carrying out its investigation, its report to the NPDB is undisputedly true." Under the law, it had no choice but to make that report, and cannot now be sued for doing so.

The critical issue for reporter immunity is not whether the reporting entity was correct in concluding that the adverse action was necessary. The sole issue is whether the adverse action report filed with the NPDB accurately reported the action that the reporting entity took. The immunity available to entities making accurate reports to the NPDB has thus been confirmed on several occasions and such reports should be filed in accordance with the purpose and goals of the HCQIA.



In order for a hospital to participate in Medicare, it must agree to the conditions of participation set forth by Medicare. Among other things, the conditions limit the use of restraints on patients.

In July 2005, the U.S. Attorney announced a unique civil settlement with a Pennsylvania medical center stemming from alleged violations of regulatory requirements pertaining to physical and chemical restraints at the hospital. The claim was brought under the Federal False Claims Act using the theory that because the hospital had violated the Medicare conditions of participation concerning the use of restraints, the resulting claims for payment constituted false claims. The government alleged that the violations of the restraint regulations resulted in the death of an elderly patient.

Although the hospital denied the allegations, it agreed to settle the claim and pay \$200,000 in fines. The hospital also agreed to hire a consultant to monitor its compliance with federal law on the use of restraints in the future.

To clarify the government's motive in bringing this suit, the U.S. Attorney stated,

"We hope that other hospitals will review carefully the procedures followed prior to, as well as after, the decision is made to place a patient in a physical restraint or to administer chemical restraint."

This case emphasizes the importance of compliance with the myriad regulations and conditions of federally financed health care programs. A similar approach to that of the U.S. Attorney in this case could be used in numerous other situations where the government wanted to enforce regulatory compliance by hitting the largest nerve in the corporate body, that leading to the bottom line. Ongoing review of practices and procedures for full compliance, and consultation with legal counsel regarding gray areas may be the best preventative measure.



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