

March/April 2009

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RED FLAG RULES TAKE EFFECT MAY 1

As a reminder to our health care clients, effective May 1 the FTC's *Red Flag Rules* take effect. Under the RFRs, any creditor, including healthcare providers who permit patients to pay over time, must adopt a policy for the purpose of identifying *red flags* that suggest possible patient identify theft, such as unusual account activity or fraud alerts. The policy must be managed by the provider's Board of Directors or senior employees, be updated regularly, and also address the prevention and mitigation of identity theft.

Please contact Mark Colucci at mjc@kgrlaw.com or Linda Batten at imb@kgrlaw.com for assistance in preparing your Identity Theft Policy.

CHALLENGES TO NON-COMPETE AGREEMENTS CONTINUE

In February, the Indiana Court of Appeals upheld a trial court decision that a physician non-compete agreement was unenforceable because it was contrary to public policy. *Mercho-Roushdi-Shoemaker-Dilley Thoraco-Vascular Corp. v. Blatchford* involved two surgeon shareholders in a group practice that provided cardiovascular services in Indianapolis and Terre Haute. As part of the stock transfer agreement, each surgeon agreed not to perform certain surgeries within fifty miles of Monument Circle in Indianapolis and within fifty miles of the Terre Haute Court House for three years after leaving the practice. As is common in group practices, the two surgeons left the group and initiated a lawsuit challenging, among other things, the enforceability of the non-compete clause in the agreement.

The appellate court noted that non-competition agreements must be reasonable to be enforced and listed three factors to determine reasonableness: 1) whether the agreement is broader than necessary to protect the employer's legitimate interests; 2) the effect

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

of the agreement upon the employee; and 3) the effect of the agreement on the public. The court determined that the group, which spent several years and several million dollars building its practice, had a protectable interest and that the time and geographical scope restrictions were no greater than necessary to protect that interest. The court also rejected the surgeons' argument that enforcement of the clauses would adversely affect their ability to make a living. However, the court agreed with the trial court that enforcement of the clause would violate public policy in light of the adverse impact enforcement of the clause would have on the community.

The surgeons presented evidence that preventing the surgeons from practicing in Terre Haute would lead to a shortage of cardiac surgeons in the area, which would result in delayed and decreased patient care, particularly in emergency situations. Importantly, the group presented no contradicting evidence. Accordingly, the court to declared the non-competes contrary to public policy because of the potential negative impact on the community of Terre Haute.

The decision comes less than a year after the Indiana Supreme Court addressed the same issue in *Central Indiana Podiatry v. Krueger*. In that case, the Indiana Supreme Court explicitly held that physician non-compete agreements were not *per se* void as against public policy but are enforceable to the extent reasonable. However, the Court noted that the non-compete agreement at issue in that case was unreasonable to the extent that it covered a wider area than the area in which the physician had patient contact.

Despite the recent opinions, the Indiana Supreme Court has made clear that non-compete agreements between physicians and group practices are enforceable as long as they are reasonable to the employer, employee and the public. What is reasonable is very dependant of the specific facts of the situation and counsel should be sought to determine the appropriate scope of such agreements.

Please contact Mark Colucci at mjc@kgrlaw.com or Linda Batten at lmb@kgrlaw.com for any questions regarding your existing or future non-compete agreements.

CMS PROVIDES EMTALA GUIDANCE TO STATE AGENCIES

On March 6, the Centers for Medicare and Medicaid Services ("CMS") issued a memorandum to State survey directors summarizing the revisions to the Emergency Medical Treatment and Labor Act ("EMTALA") regulations that became effective October 1, 2008, and

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

provides significant changes to the regulations.

The first change introduces a shared community call plan (“CCP”) that allows multiple hospitals to enter into a formal agreement to share on-call responsibilities for meeting the requirements under EMTALA. A formal CCP must include:

- clearly delineated on-call responsibilities, including time periods and types of services;
- a description of the relevant geographic area;
- a signature from each participating hospital;
- assurances that the local EMS system protocol includes information on the CCP arrangement;
- a statement that a hospital must abide by EMTALA regulations if a patient arrives at a hospital that is not on-call; and
- an annual assessment of the CCP by the participating hospitals.

The memorandum also includes additional guidance on appropriate handling of certain situations between hospitals in a CCP. For example, CMS advises that under a formal CCP, if an individual presents to a dedicated emergency department of a hospital and requires services of a specialist for stabilizing treatment, and another participating hospital in the CCP has the responsibility for providing that service, “then a transfer to the hospital with the available on-call specialist would generally be appropriate, assuming all other transfer requirements are met.”

The CMS memorandum also summarizes a change to allow hospitals to utilize an EMTALA waiver in the case of natural disasters, including weather related disasters. The hospital is required to notify its State agency (such as the Indiana State Department of Health). CMS indicates that the notification allows it to track numbers and locations of hospitals that utilize waivers.

Finally, CMS clarifies the obligations for hospitals with specialized capabilities. Once an individual is admitted in good faith to a hospital that has satisfied its obligations under EMTALA, even though the individual remains in an unstable condition, the hospital with specialized capabilities is not obligated under EMTALA to accept an appropriate transfer of that individual.

The CMS memorandum is timely given recent EMTALA media attention and court cases. It is also important for hospitals and on-call physicians to understand their obligations and liabilities under

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

EMTALA and make sure any agreements between parties for on-call services specify those obligations to and expectations.

For more information contact Linda Batten at lmb@kgrlaw.com or Mark Colucci at mjc@kgrlaw.com.

TEXAS HOSPITAL PAYS \$10 MILLION FRAUD AND ABUSE SETTLEMENT

In its effort to recoup and prevent waste and abuse related to Medicare claims, the federal government is increasing efforts to identify hospitals, providers, and medical equipment companies that have been paid more than the government believes was required from the Medicare program.

On March 26, the Justice Department announced that Methodist Hospital ("Methodist") in Houston agreed to pay the U.S. government \$10 million to resolve allegations of fraud and abuse of Medicare's outlier program between 2001 and 2003. Specifically, the government alleged that Methodist increased charges, without regard to actual costs, to obtain bigger payments from the outlier program, which is intended to compensate hospitals for unusually expensive care.

Methodist denied the government's contentions that it "improperly increased charges to Medicare patients to obtain enhanced reimbursement from the federal health insurance program for the elderly." Methodist stated that it entered the settlement agreement to be able to "continue focusing on its clinical and academic missions."

While many similar fraud and abuse actions against hospitals are the result of qui tam whistleblower lawsuits, Methodist's Chief Legal Officer, Mick Cantu speculated that the Justice Department was working through a list of the hospitals that received the highest outlier payments that was provided to Congress in 2003 testimony by then-CMS Administrator Thomas Scully. Cantu said the hospital's overall costs for Medicare services exceeded payments during the time in question, and attributed the outlier issue to "a failure on the part of the Medicare fiscal intermediary to update the hospital's cost-to-charge ratio."

The large settlement suggests the aggressive nature of government recoupment efforts against hospitals and healthcare providers. Given the recent launch of the recovery audit contractor

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mjc@kgrlaw.com

lmb@kgrlaw.com

program in Indiana, healthcare providers should be vigilant in their billing and compliance programs.

For more information contact Linda Batten at lmb@kgrlaw.com or Mark Colucci at mjc@kgrlaw.com.
