CCH Healthcare Compliance LETTER

Volume 7, Issue 4 www.cchgroup.com February 23, 2004

FTC levels antitrust complaint against hospital merger

by Sharon Sofinski

The Federal Trade Commission (FTC) has issued an antitrust complaint against Evanston Northwestern Healthcare Corporation (ENH) alleging that its recent merger violates the Clayton Act and that it engaged in illegal price fixing in violation of the FTC Act.

Merger. In January 2000, ENH merged its Evanston and Glenbrook hospitals with Highland Park Hospital. Shortly after that merger, ENH negotiated uniform prices for the three hospitals as a single system and increased prices at all three hospitals. According to the FTC, the resulting anticompetitive price increases were "large and far beyond those achieved by comparable hospitals during this time period."

Prior to the merger, the complaint alleges, the Evanston and Glenbrook hospitals had operating costs comparable to other area hospitals. After the merger, its operating costs increased well beyond operating costs at comparable hospitals.

Price fixing. The FTC's complaint also alleges that ENH Medical Group engaged in price fixing of physician services after the Highland Park Independent Physician Association was folded into the Group as part of the merger. The resulting Group negotiated prices for physicians employed by ENH Medical Group as well as prices for hundreds of independent physicans not employed by ENH. The move "deprived commercial payers, employers, and individuals the benefits of competition in physician services," according to the FTC complaint.

Mark Neaman, ENH's President and CEO, issued a statement assuring that ENH will fight the FTC action. Calling the allegations "false and not supported by the evidence", Neaman said ENH "will vigorously defend the merger and we believe that we will prevail." He added, "The FTC's attempt to undo the merger ignores the enormous benefits of the merger and demonstrates disregard for the health and welfare of the families and communities we are privileged to serve."

Hearing. The FTC's allegations will be brought before an administrative law judge in Washington in May 2004.

The FTC's press release, with a link to the FTC complaint, can be found at http://www.ftc.gov/opa/2004/02/enh.htm. ■

CCH Chicago Bureau, February 13, 2004

$4.1 million Medicare fraud settlement announced

by Sharon Sofinski

Coast Plaza Doctors Hospital and the estate of its former chief executive officer have agreed to pay $4,106,735 to settle allegations that they defrauded Medicare. The settlement was announced on January 29 by Debra W. Yang, United States Attorney for the Central District of California.

In 1999, Coast Plaza's former chief financial officer filed a whistleblower lawsuit alleging that from 1994 through 1999, Coast Plaza wrote checks to a number of vendors and other payees, posting the check amounts as expenses, then claiming and receiving reimbursement from Medicare for a portion of the expenses. Coast Plaza never delivered the checks to the vendors or payees; instead, it allegedly voided them and accounted for them as "checks held" or "discount friend of CPDH".

The lawsuit alleged that Coast Plaza and its former CEO failed to offset the voided amounts against allowable and reimbursable costs claimed from Medicare, meaning they received reimbursement from Medicare for expenses they never actually paid.

In addition, Coast Plaza allegedly received additional Medicare funds to which it was not entitled by billing Medicare for expenses that were not related to caring for Medicare patients and for expenses that were not allowable under Medicare regulations.

The former CEO of Coast Plaza who was involved in the fraudulent activities died in an automobile accident in 2002. His estate has agreed to accept the financial responsibility for the settlement, along with Coast Plaza. The former CFO, who "blew the whistle" on the fraudulent activities, is entitled to 17.5 percent ($718,678.63) of the settlement under the *qui tam* provisions of the False Claims Act.

Coast Plaza, a 123-bed acute care facility in Norwalk, California, has also executed a corporate integrity agreement with the U.S. Department of Health and Human Services (HHS).

The U.S. Attorney's press release is at: http://www.usdoj.gov/usao/cac/pr2004/011.html. ■

CCH Chicago Bureau, February 11, 2004

Twenty indicted in multimillion-dollar health fraud scheme

by Sharon Sofinski

Marcus Daniel Jimenez, United States Attorney for the Southern District of Florida, has announced a 26-count indictment charging 20 people with conspiracy to commit healthcare fraud.

The indictment charges that between 1997 and 2002, Heldy Artiles and Orlando Artiles, Jr., "conspired with physicians, a physician's assistant, physical therapists, and others to fraudulently bill Medicare and private insurance companies for approximately $5.5 million of medical services, medical equipment, medications, and physical therapy that was either not provided or was medically unnecessary."

The Artileses and their co-conspirators allegedly paid kickbacks to people posing as patients of Miami Health Medical Center and other medical companies, including Exclusive Medical Supply, Inc.; Hope Medical Supplies, Inc.; Miami durable medical equipment companies; and Ideal Pharmacy. Medicare has ceased making payments to all four companies.

The co-defendants also are charged with:

- coaching "patients" to fake medical problems during visits to Miami Health;
- falsifying doctor's notes;
- falsifying patient medical records by adding false patient complaints;
- fabricating doctors' diagnoses and treatment plans; and
- ordering unnecessary tests, medications, physical therapy, and equipment.

Three physicians who are among the 20 indicted are charged with signing and approving altered medical records and fraudulent prescriptions with the knowledge that patient office visits never occurred and that unnecessary tests, medications, physical therapy, and equipment were ordered.

Four of those indicted also face charges of conspiracy to commit money laundering with the proceeds of the health care fraud scheme. In addition to the health care fraud charges, three of the twenty people indicted face additional charges of conspiracy to tamper with witnesses, three face additional charges of paying illegal healthcare kickbacks, and two face additional charges of witness tampering.

The Federal Bureau of Investigation (FBI), the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG), the U.S. Postal Inspection Service, and the National In-

continued on page 7

CCH Healthcare Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Healthcare Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

Expert anticipates increased efforts to curb research conflicts of interest

by Catherine Hubbard, MA, Contributing Editor

Congress and government agencies are increasing their focus on preventing conflicts of interest issues from compromising the safety and quality of clinical research. "There will be increased focus on the issue from Congress," predicted F. Lisa Murtha, chief privacy officer for The Children's Hospital of Philadelphia. She also predicted increased regulation and guidance from the Food and Drug Administration, NIH's Office for Human Research Protections and other federal agencies.

Already, Reps. Billy Tauzin, R-La., and James Greenwood, R-Penn., have launched a broad investigation into NIH grant-making decisions after discovering alleged improprieties in how grants were distributed. The lawmakers now want full accounting of industry payment to NIH employees.

Types of conflict of interest. In the scientific and academic arenas, the potential for personal gain must not jeopardize or appear to jeopardize the integrity of the research process including the choice of research, its design, the interpretation of results and the reporting of results, said Murtha. Most anyone involved in the trial, including researchers, technicians, Institutional Review Board (IRB) members and study coordinators, can have a conflict of interest. For example, an individual might expect a financial reward, such as a consulting fee, that influences him or her to prefer one outcome over another. Or a faculty member or researcher may owe his or her primary commitment to an institution or be involved in a commercial venture, such as consulting or serving on a board of directors, she said. She spoke during a recent conference call sponsored by the Health Care Compliance Association.

Conflicts of conscience also can arise when scientists with deeply held personal views are asked to judge projects that are, in principle, unacceptable to the reviewer, Murtha said. For instance, this can occur when a scientist who opposes all research using laboratory animals is asked to determine the merit of a study or report that is based upon such use, she noted.

Institutional conflicts of interest can occur when interests of the institution might affect the conduct, review or oversight of human research, Murtha said. "If an institution owns a financial interest in a company that holds a patent to a new drug or device, a conflict and/or a perception of a conflict can arise," she said.

Conflicts of interest at universities can compromise research, endanger human subjects' safety, jeopardize the public's faith in findings or lead potential subjects to question whether the investigator is acting in their best interest or merely using them as a vehicle for conducting research. Such conflicts may also reduce the public's willingness to participate in studies, which could inhibit future discoveries, she said.

To prevent a conflict and avoid lawsuits, universities need to develop more precise policies and procedures that define conflict of interest and lay out how to identify, disclose and handle conflicts, Murtha advised. She noted that failure to manage potential conflicts of interest can lead to lawsuits if a human subject is harmed.

One of the most common conflicts of interest, however, involves financial ties, Murtha said. She advised managers to:

- Create a precise definition as to what constitutes a financial conflict of interest.
- Articulate what is allowed in terms of investments, payments, bonuses and other fees and intellectual property rights.
- Establish enforcement mechanisms and sanctions.
- Design educational programs for all researchers, data managers, IRB members and institutional officials with research and finance decision-making responsibilities.
- Establish a firewall between offices responsible for financial decisions and those responsible for research decisions.
- Establish a standing conflict of interest committee to review financial interests, determine the appropriate action if there is a conflict, document decisions, monitor procedures and conditions surrounding research involving a financially interested individual and communicating regularly with the IRB. ■

CCH Washington Bureau, February 12, 2004

On The Front Lines

Patient Safety and Compliance

by Barbara Balik, RN, Ed.D., and Pamela Ross, JD, MHA

In this article, Barbara Balik, RN, Ed.D., Executive Vice President, Safety and Quality Systems, and Pamela Ross, JD, MHA, Director Corporate Compliance, both of Allina Hospitals & Clinics, explain the elements of a patient safety culture, what Allina is doing to promote a patient safety culture, and the link between patient safety and compliance.

At Allina, it is our mission to serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care. It is our vision to always put the patient first and to make a difference in people's lives by providing exceptional care and service. Obviously, a fundamental part of providing exceptional care is providing safe care. Our patients deserve it, our employees advocate for it, and the public expects it.

It is easy to understand why patient safety is important to healthcare organizations. First, there is the direct impact on patients and their families. But it is more than that. A bad outcome can affect an entire organization. When a healthcare organization fails to provide a safe care environment for its patients, there is a loss of trust and confidence in the organization and in its employees as individuals. Along those lines, there can be a personal effect on the caregivers involved, since any episode of patient harm can negatively impact individual and team morale. And finally, there is the potential loss of reputation, negative media publicity, and the possibility of legal action against individuals and the organization.

What Is a Patient Safety Culture?

So, what kind of environment promotes a safety culture? What characteristics allow healthcare organizations to deliver the safest health care to its patients? The six key characteristics of a safety culture are:

- Well-designed processes
- Evidence-based care
- Skillful people
- Respectful and effective teams
- Talented leadership
- Support for learning, reporting and justice

Let's talk about each of these in detail.

Well-Designed Processes

The key to safe care is the use of well-designed processes. Processes are the steps that are taken to complete an activity. If you think of the medication process, first a physician or other qualified caregiver assesses the patient and makes a diagnosis. The caregiver determines whether medication is required to treat the patient's condition. If so, the caregiver decides what type of medication is appropriate, what dosage is required, and whether there will be any interactions with other physical conditions the patient has or any other medications the patient is currently taking. After these decisions are made, an order is written for the medication. In a hospital setting, the next step in the process may be for a RN to review the medication order, and then the order is entered into the computer system by hospital staff. Then the pharmacy receives and reviews the order. The medication is then dispensed to the patient care unit and administered to the patient by the nurse. Or, in a clinic or outpatient setting, the patient takes the prescription to his or her local pharmacy where the pharmacist fills the prescription correctly and then the patient takes the right dose.

While we have oversimplified the steps here, one thing is clear: there are many steps involved in the medication process. And, the more steps, the greater the possibility that one of those steps could result in an error, such as the pharmacist misreading the physician's handwriting and filling the prescription incorrectly. What we have learned at Allina is that the best processes are designed to have a few simple steps. Every step should be visible so that everyone knows what should happen at each step, allowing us to stop the process if something is not going as planned. At Allina, we are currently implementing an automated medical record (AMR), which will help make such steps more visible and understandable.

Processes designed in anticipation of failure can also help create a safer environment. Throughout Allina, we are using a failure mode effect analysis (FMEA) approach to designing safer systems. Basically, FMEA acknowledges that systems can fail, and seeks to correct those failures before we implement a given process. In other words, as we build our processes we are on the lookout for potential errors, and we proactively design ways to avoid them.

An example is Allina's recent use of FMEA to improve the process for heparin medication administration. To ensure we are consistently giving appropriate doses of heparin, we explored what errors were occurring in the existing medica-

tion administration protocol. We then designed safety into each step of the process and have been able to simplify the medication administration process with positive outcomes. We also utilized FMEA to prevent errors when we introduced new IV pumps. By closely looking at the practices and functionalities of the "old" IV pumps compared with the "new" IV pumps, we were able to design a safer process and avoid potential errors associated with the habits we developed using the old pumps.

Well-designed processes have built-in safety steps. These safety steps are mechanisms built into a process that make it easy to do the right thing and hard to do the wrong thing. Some safety steps provide clear guidance on what to do, such as the written instructions on programming particular devices or machines. Other safety steps provide alarms or warnings letting caregivers know that a patient's heart rate is not in an appropriate range. Safety steps can also be safety barriers such as oral syringes specifically designed so that they cannot be connected to IV tubing.

Evidence-Based Care

Evidence-based care is care that is based on the best-known science available, combined with expert judgment and provided in a way that is consistent with the patient's values. It means that we do not provide care based solely our individual preferences, the information we learned during our education, or an individual's personal habits or approach to care. Currently, it takes 17 years for new scientifically proven practices to be adopted into practice, and even then, the use of the new practices is inconsistent.

The consistent use of evidence-based care assures patients that we are constantly looking at the newest research and the best possible practices. Within Allina, our Pregnancy Care Council has developed recognized guidelines for caring for obstetric patients that have been implemented throughout Allina. These guidelines are well grounded in evidence-based care and have yielded better outcomes for mothers and their babies.

Skillful People

Skillful people also provide safe care. Individuals providing direct care and those supporting caregivers need to know what skills are necessary to provide safe and effective care. They need to know their role, what is expected of them, and ways they can contribute to providing the safest care to patients and their families. And, once these skills are identified, education and training are required to make sure these skills are fully developed. Providing meaningful education and training is also important because it reduces the reliance on memory and promotes a system-level understanding of our work.

Throughout Allina, we engage in various activities to ensure our employees have the skills they need. For example, caregivers regularly receive information through orientation, preceptorships, skills days, competencies and other ongoing educational activities designed to build and maintain skills.

Respectful and Effective Teams

We also know that effective and respectful teams provide the safest care. People who work together without respectful communication and supportive team interactions are at greater risk of harming patients than those who work well together. Studies have repeatedly shown that positive communication and respectful teamwork improves safety, lowers caregiver stress, and improves patient satisfaction. To help build and maintain respectful and effective teams, Allina is working to promote team-building activities throughout the organization. Additionally, Allina has a respectful workplace policy we strive to abide by everyday.

Talented Leadership

Strong leadership also plays an important role in the delivery of safe care. It is important to note that leaders are not just those in senior management positions, but anyone who takes an active role in leading a project or group of people. Talented leadership ensures we are identifying and promoting the most well designed processes while making sure that people are working as a team. Part of developing an effective team is making sure that team members are well trained, are clear about their roles, and understand the importance of identifying, reporting and learning from good catches and actual errors in order to build safe systems and processes in the future. Talented leaders also strive to create a workplace where employees feel safe and supported by management. In this type of environment, employees are comfortable offering ideas for the delivery of safer and more effective care and services to patients and their families.

Learning, Reporting and Justice

Finally, the safest care occurs in an environment that supports learning, reporting and justice. *Learning* is the ongoing interest in understanding how we can do things better. It involves listening to each other and learning how to do things in a safer, more effective way.

Reporting means sharing information with managers and peers when an error occurs by using Allina's patient/visitor safety reporting form to report all types of safety events and potential hazards. Unless we report safety events and concerns, we are not fully aware of our risks and unable to improve our processes to make our environment safer. Our patient

safety reporting structure is a consistent way for all caregivers to report errors, good catches, and potential hazards and allows us to react appropriately to change our practices.

Justice refers to an organizational culture that does not blame individuals for the failure of a larger system or process. Healthcare errors are rarely the result of a single error caused by a single individual. Rather, they are almost always the result of multiple failures in a very complex system. An organization that promotes justice will avoid finger pointing. Instead, the organization will work to understand why the error occurred and will modify or create new systems to prevent the error from happening again.

Within Allina we are committed to a blameless culture where we recognize that errors can occur because of processes. We want to foster a culture where reporting errors and learning from those errors is a fundamental part of who we are. What is most important to us is avoiding harm to our patients—not assigning blame.

What Allina Is Doing to Promote a Patient Safety Culture

In addition to implementing an automated medical record (AMR), Allina is engaged in other activities to enhance patient safety. Notably, during 2003 Allina's CEO, Dick Pettingill, required that the organization's 75 most senior leaders participate in "Safety Walkarounds." Each leader visited two patient care sites to better understand the safety issues from the perspective of the caregivers treating patients at those sites. This provided an important opportunity to see firsthand the types of issues we must continue to address to improve patient safety. Based on the success of this program, safety rounds are continuing at sites throughout the organization. Leaders also participated in educational sessions regarding patient safety so they are better equipped to assist with the development and leadership of safer systems. "Patient safety has always been a priority at Allina," says Pettingill. "I continue to be impressed with the commitment of our caregivers and our leadership to promote a safe care environment. Our current efforts around patient safety reflect our ongoing belief that providing safe care is integral to providing quality care."

Allina is also busy implementing measurement systems to help us identify our safety risks and determine whether or not we are making progress in our efforts to improve patient safety. For example, we regularly maintain and review our patient and visitor safety reports to identify opportunities to improve patient safety locally and throughout the organization. Risk and quality staff across Allina have worked to ensure that our reporting systems are consistent in all settings so we can better understand the issues we are experiencing Allina-wide and work to develop the best systems to address them. This also allows us to take advantage of the expertise of our co-workers and the well designed processes that have already been developed.

For instance, extensive patient safety work has been conducted around the organization regarding patient falls. One site evaluated our current fall assessment tool (which identifies those patients at risk for falls) to determine the effectiveness of the tool. As a result of its research, the site ultimately identified and implemented another tool that was a better predictor of patient falls. Another site implemented safety steps such as an alarm that triggers when a patient attempts to get out of bed unassisted, and the placement of "fall risk" stickers on the patient's door. Use of these stickers has helped all staff become more alert to the potential for patient falls. We are now taking this information and designing Allina-wide best practices regarding fall prevention.

Another initiative underway at Allina is our ongoing partnership with patients to promote patient safety and well-being. One of our hospitals conducted focus groups with patients, families and caregivers to better appreciate how patients view their role in the delivery of safe care. Patients told us that they would feel safer and more capable of participating in their care if they better understood what to expect during the course of their care. Based on this feedback, we have been developing and communicating "patient pathways" to clearly articulate to patients and their families the steps associated with the patients' care. We also learned that patients are more likely to "speak up" about safety concerns when caregivers specifically ask them if they feel safe. As a result we have developed brochures encouraging patients to speak up and share their concerns with us. These tools are being shared throughout the organization.

Allina has long recognized the importance of talking to patients openly and honestly when something goes wrong. As we have learned, sometimes despite our best intentions, harm does occur. Things also go wrong for other reasons, such as complications due to the patient's previous health history. Regardless, we have an obligation to discuss these situations with our patients, however difficult it may be. To help caregivers have these difficult conversations we recently organized "disclosure education." Partnering with the nationally recognized Bayer Institute, we sponsored a course on how to disclose difficult information to patients and their families and plan to share this information throughout Allina.

Additionally, our current patient safety initiatives and goals compliment much of the work that is being done to achieve the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) National Patient Safety Goals.

Connection to Compliance

Part of our commitment to compliance is doing it right each and every time. That includes avoiding errors and providing the most appropriate care to our patients in the safest environment. In addition, governmental entities on both the state and national level now view quality as one of the key measures of compliance. According to David Orbuch, Allina's Corporate Compliance Officer, the landscape of the compliance environment has changed significantly to incorporate issues around quality and safety. "Five

On The Front Lines (cont.)

years ago, the main focus of compliance activities was almost exclusively in the billing and coding realm. Now, there is a growing recognition that compliance encompasses a broader range of the healthcare experience. At Allina, part of our commitment to compliance is a commitment to providing safe and quality care."

State Initiatives

In June 2003, Minnesota Governor Tim Pawlenty signed into law a bill requiring hospitals to report to the Minnesota Department of Health (MDH) when certain adverse events occur. The Minnesota Adverse Health Care Events Reporting Act of 2003 identifies 27 types of "Never Events" (events that should never occur) that must be reported to MDH, including wrong-site surgery, retention of foreign objects after surgery, and death and serious disability due to medication errors. Allina is working with employees to modify current processes to ensure compliance with the law and make sure that the "never events" never occur.

Federal Initiatives

States are not the only governmental entities looking into quality of care. The federal government is also considering new ways to address quality of care issues, particularly in the hospital setting.

There's a new twist emerging in the use of an old law—the federal False Claims Act (FCA). Prosecutors are now pursuing quality and safety in their efforts to combat fraud and abuse in the hospital setting. Historically, in the health care arena, the FCA has been used as a tool for the government to prosecute health care providers who improperly bill federal health care programs such as Medicare and Medicaid. Organizations prosecuted under the FCA face serious consequences, including damages of up to three times the amount of the each alleged false claim.

Here is the theory: Government prosecutors believe that a hospital has engaged in fraudulent billing if the hospital delivers unnecessary or inadequate care (which, in the eyes of the government is essentially the equivalent of no care at all), and subsequently bills the government for these services.

According to Associate U.S. Attorney James Sheehan, in cases pertaining to either unnecessary or inadequate care, prosecutors are looking for continuing incidents of hospitals failing to make systemic changes once quality and safety problems are identified. It is unlikely that hospitals will face prosecution for single instances of billing for unnecessary or inappropriate services. However, there is growing momentum among federal prosecutors to go after organizations that fail to address quality of care issues.

Clearly, quality is on the minds of health care and government leaders, as well as the public. While improving quality and safety is imperative to complying with state and federal laws, it's also essential to our promise to always put our patients first. ■

Allina Hospitals & Clinics is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. Allina offers a vast array of services and programs through its dedicated workforce of more than 22,000 employees. Allina provides a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy and hospice services.

Fraud & Abuse (cont.)

surance Crime Bureau participated in the investigation. The U.S. Attorney's press release is at http://www.usdoj.gov/usao/fls/Artiles.html. ■

CCH Chicago Bureau, February 11, 2004

OIG announces $9.5 million settlement

by Sharon Sofinski

The Office of Inspector General (OIG) announced a settlement under its Provider Self-Disclosure Protocol with St. Francis Hospital, Inc. St. Francis has agreed to pay nearly $9.5 million to settle Medicare billing and documentation improprieties.

The improprieties took place from 1997 to 1999 and involved St. Francis's home health, hospice, and durable medical equipment programs. Bon Secours Health System, Inc. discovered the problems when purchasing St. Francis in 2000. Bon Secours launched an internal investigation that uncovered "significant error rates and systematic documentation lapses" in St. Francis's Medicare billings. St. Francis relayed the findings to the OIG under the Self-Disclosure Protocol.

The Self-Disclosure Protocol encourages providers to voluntarily notify the OIG when they discover fraud or compliance problems in their organization. Under the Protocol, OIG guides providers on how to investigate and audit such problems and helps them come to a quick resolution. In this case, since St. Francis self-disclosed the billing improprieties, the damages imposed are much lower than the damages that would have been imposed by the government under the Civil Monetary Penalty Law.

Also, because St. Francis voluntarily reported the problems, quickly took corrective steps to remedy them, and implemented a solid compliance program when purchased by Bon Secours, the OIG did not require St. Francis to enter into a corporate integrity agreement.

Acting Principal Deputy Inspector General Dara Corrigan called the settlement "a good example of how the Self-Disclosure Protocol benefits both the integrity of Government health care programs and providers who discover and report evidence of potential fraud and overbilling in their organization." The $9.5 million settlement is the largest ever reached solely under the OIG's administrative authorities.

The OIG news release is at http://www.oig.hhs.gov/publications/docs/press/2003/021104Stfrancis--pressrelease.pdf. For more information on the OIG's Self-Disclosure Protocol, see http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf. ■

CCH Chicago Bureau, February 11, 2004

DOL recovers overtime back pay for New Jersey nurses

by Ronald Miller, JD, Contributing Editor

The U.S. Department of Labor (DOL) has announced a settlement with a Wayne, New Jersey company to pay 36 of its registered nurses $218,959 in overtime back pay for violations of the overtime requirements of the Fair Labor Standards Act (FLSA). The registered nurses were employed by CritiCare L.L.C. and assigned to work at area hospitals in New York and New Jersey.

"The Department is dedicated to ensuring that all workers who are entitled to overtime pay under the Fair Labor Standards Act receive their full wages," said Secretary of Labor Elaine L. Chao. "The nearly $219,000 in overtime back wages due to the nurses in this case were significant. This Administration has set new records for protecting workers' pay, benefits and safety, and today's action further demonstrates our commitment."

An investigation by the department's Wage and Hour Division disclosed that the registered nurses were paid straight time for hours worked over 40 in a workweek. The investigation further disclosed that the firm required the nurses to sign waivers that relieved the company of the obligation to pay them overtime.

The FLSA requires the payment of time and one-half an employee's regular rate of pay after 40 hours worked in a workweek. The language of the Act and controlling court decisions make clear that covered employees cannot waive their statutory right to overtime pay.

Once notified that the waivers were invalid, the company agreed to cooperate fully with the investigation, comply in the future, and pay back wages covering a two-year period of time.

The Employment Standards Administration Wage and Hour Division (WHD) recovered more than $212 million in back wages in fiscal year (FY) 2003—a 21 percent increase over the record setting amount in FY 2002. Average days to resolve a complaint decreased in FY 2003 from 129 days to 108 days. WHD assessed employers nearly $10 million in civil money penalties in FY 2003. ■

CCH Chicago Bureau, February 2, 2004

Nurse's age bias claim fails

by Robyn McCain, JD, Contributing Editor

A 51-year-old nurse's age bias claim failed where she was unable to show by a preponderance of evidence that she was not hired for one of the positions she interviewed for upon her return from medical leave due to her age, concluded the Sixth Circuit Court of Appeals. The nurse took a medical leave of absence to recuperate from surgery on a badly broken leg. When she was released to work, she underwent a functional capacity evaluation to determine if she was able to work, and if so, if she would have any limitations. Based on the results of the evaluation, the nurse requested to be placed on the employer's list of employees with permanent work restrictions. Once on the list, she could be considered for an alternative position. (*Hedrick v. Western Reserve Care System*, 6thCir.)

The nurse refused the first alternate position she was offered because the salary was too low. In the following months she interviewed for several more positions, but other candidates were selected. Eventually, she accepted a temporary admissions nurse position for the same salary and benefits as her pre-leave position. Approximately two years later, she filed an age discrimination claim. A federal district court granted summary judgment in favor of the employer.

On appeal, the nurse argued that the district court required her to provide evidence of discrimination beyond the evidence necessary to show that the employer's reasons for not hiring her were pretextual. The appellate court noted that the district court's opinion specifically stated that even if the employer's reasons could not be believed, the nurse failed to raise an inference of age bias. Because the appellate court also found that the nurse's evidence of pretext was insufficient, summary judgment in favor of the employer was affirmed. ■

CCH Chicago Bureau, February 2, 2004

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.