CCH Healthcare Compliance LETTER

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FTC, DOJ release joint report on health care competition

by CCH Editorial Staff

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) released a joint report on July 23 that reviewed the role of competition in health care and offered a wide range of advice on how to improve the balance between competition and regulation in the industry. According to the report, costs could be lowered and quality could be enhanced by a concerted effort on the part of private payers, governments, and providers to improve their measures of price and quality and to give consumers more information about each. In addition, the report found numerous actions that state governments and federal enforcement agencies could undertake to improve competition.

The report suggested that states consider taking steps to decrease barriers to entering provider markets. For instance, they should consider broadening the membership of state licensing boards, since boards with broader membership would be less likely to limit competition. States also should consider implementing uniform licensing standards to reduce barriers to telemedicine and competition from out-of-state providers.

The joint report recommended that governments re-examine the role of health care subsidies, in light of those subsidies' inefficiencies and potential to distort competition. They should not permit independent physicians to bargain collectively because collective bargaining leads to higher prices and is unlikely to result in better care. In deciding whether to mandate particular benefits, governments should consider that mandates are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans.

The report also offered guidance on several specific antitrust enforcement issues. Among the agencies' conclusions were: (1) the "hypothetical monopolist" test of the Merger Guidelines should be used to define geographic markets in hospital merger cases; (2) a hospital merger analysis should not be affected by a hospital's institutional status; and (3) the safety zone provision of the agencies' Statements of Antitrust Enforcement Policy in Health Care did not protect anticompetitive contracting practices of group purchasing organizations.

In a statement accompanying the release of the report, FTC Chairman Timothy J. Muris remarked that "[c]onsumers want high-quality, affordable, accessible health care, and the challenge of providing it requires new strategies." He added that "[v]igorous competition promotes the delivery of high-quality, cost-effective health care." The report, entitled "Improving Health Care: A Dose of Competition," was based on 27 days of hearings held by the agencies from February through October 2003, an FTC-sponsored workshop in September 2002, and independent research. The report can be viewed at: http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ■

CCH Chicago Bureau, July 28, 2004

Lawmakers propose change in hospital accreditation authority

by Paula Cruickshank, Contributing Editor

In response to a study by the General Accounting Office (GAO) critical of the quality of work done by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Sen. Charles E. Grassley, R-Iowa and Rep. Pete Stark, D-California, introduced legislation to transfer authority over the accreditation of hospitals, which currently rests with JCAHO, to the Centers of Medicare and Medicaid Services (CMS). The Medicare Hospital Accreditation Act of 2004 (H.R. 4877) was introduced on July 20 by Stark in the House and co-sponsored in the Senate (S. 2698) by Grassley and Max Baucus, D-Montana.

The bill would amend title XVIII of the Social Security Act to revoke the unique ability of JCAHO to deem hospitals to meet certain requirements under the Medicare program and to provide for greater accountability of the Joint Commission to the Secretary of Health and Human Services. Grassley, at a July 20 news conference, noted that the proposal would give the federal government the same oversight authority for the accreditation of hospitals that it has for other health care providers. "Expanding oversight by CMS of JCAHO's hospital accreditation will help improve the process, keep patients safe and ensure that hospitals continue to perform to our expectations," said Baucus in a written statement.

The GAO study found that JCAHO's hospital accreditation process, over a three-year period, did not identify most of the deficiencies in a sampling of hospitals that were found by state survey agencies. In a survey of 500 JCAHO-accredited hospitals conducted in fiscal years 2000 through 2002, state agencies found 31 percent, or 157 of the surveyed hospitals, with deficiencies in Medicare requirements. Of these 157 hospitals, JCAHO did not identify deficiencies in 78 percent, or 123, of the health care facilities.

> **"Expanding oversight by CMS of JCAHO's hospital accreditation will help improve the process, keep patients safe and ensure that hospitals continue to perform to our expectations."**

"Congress expects the Joint Commission to be a consumer watchdog on behalf of patients. However, based on what the GAO found in this new report and what an Inspector General found in 1999, it looks like the Joint Commission is instead a lapdog," asserted Grassley. "I think this puts CMS clearly in charge. All the bill does is say that instead of working for a board that is largely comprised of hospital executives, you will be working for the federal government, who pays a large share of the bills and is responsible for a large share of the patients that come to your hospitals," explained Stark at the news conference.

Noting that there are less than 25 working days left on a busy legislative calendar, Grassley, who is chairman of the Senate Finance Committee, acknowledged that time constraints could keep Congress from enacting the Medicare hospital accreditation bill in 2004. However, Grassley said he would like to see at least committee action on the measure before the end of the 108th session of Congress. ■

CCH Washington Bureau, July 26, 2004

Letters to the Editor

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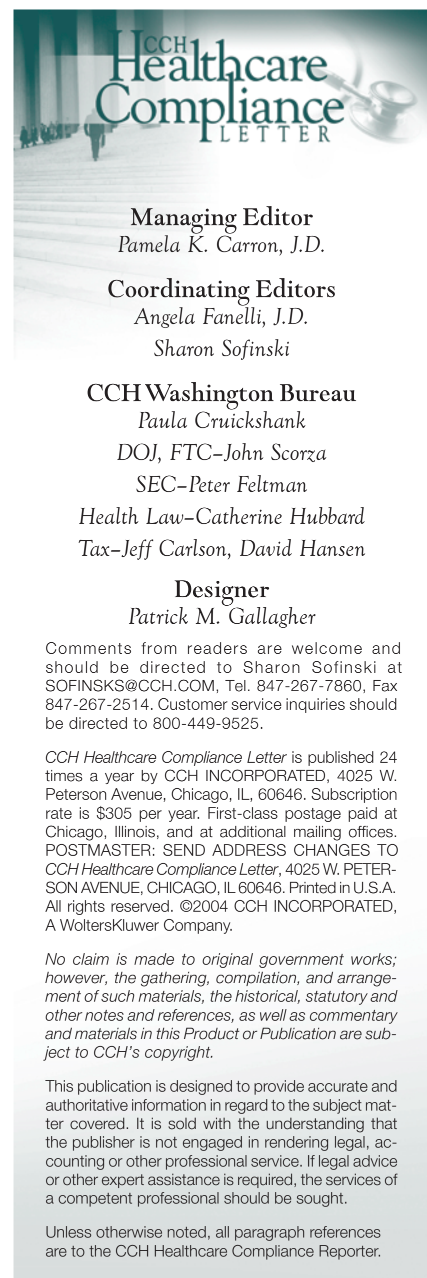

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Unless otherwise noted, all paragraph references are to the CCH Healthcare Compliance Reporter.

Health organizations need to improve tracking of PHI to conform to Homeland Security and Patriot Acts, experts predict

by Catherine Hubbard, MA, Contributing Editor

Health information managers need to broaden their understanding of what they need to track and report in light of the Homeland Security and Patriot Acts, according to experts who spoke during a recent audio conference.

"As the keepers of information where data is stored in the health organization, it is important that the health information management professionals recognize the point of origin for data and how that data is managed and how that data may or may not be shared," said John Eckmann, director of the informatics core at the General Clinical Research Center on the Health Sciences Center campus of the University of Oklahoma. "It's very difficult to manage what you're not aware of," he said during a July 20 audio seminar sponsored by the American Health Information Management Association.

Elisa Gorton, manager of health information services and the privacy officer at Hall-Brooke Behavioral Health Services in Westport, Connecticut, advised organizations to find out where all health information is stored within an organization. Medical information can exist in different computer systems within different departments, systems as divergent as billing and correspondence, she said, warning that not all information makes it into the medical record. "The health information manager has to investigate where the information is," she said. "Under HIPAA, they will have to find it."

Gorton noted that both laws, which allow the federal government to obtain personal health information for national security purposes, are consistent with HIPAA. "Both of these pieces of legislation provide for the protection of the PHI," Gorton said, noting that the request for PHI from the authorized agent must be in writing and signed by a judge. Furthermore, she noted, civil liabilities for redislcosure of PHI is stipulated in the act.

In addition, Gorton offered some guidelines to facilities that are releasing PHI to the federal government:

- Always ask the requestor for identification.
- Always make a copy of the identification.
- Ask on whose behalf the request is being made (e.g., which government branch, office location, which law enforcement agency).
- Make sure that the request is signed by a judge.
- Only provide the minimum necessary PHI that is requested. ■

CCH Washington Bureau, August 2, 2004

Shared system maintenance required for HIPAA transaction errors

by Gené Stephens Connolly, JD, Contributing Editor

Shared system maintainers must reserve hours in the January 2005 release for Health Insurance Portability and Accountability Act (HIPAA) transactions. A CMS One-Time Notification requires shared system maintainers to comply with HIPAA implementation guidelines by identifying and resolving HIPAA programming errors in a timely manner. The Manual further provides business requirements for all shared system maintainers. The implementation date for HIPAA error resolution is January 1, 2005. ■

CCH Chicago Bureau, July 30, 2004

HIPAA exemption for self-funded, non-federal group plans

by Gené Stephens Connolly, JD, Contributing Editor

CMS finalized an Interim Final Rule previously issued on July 26, 2002, that amended existing exemption election requirements for non-federal, self-funded group health insurance plans from Title I of the Health Insurance Portability and Accountability (HIPAA) Act of 1996. The regulations amending 45 C.F.R. § 146.180 became effective on September 24, 2002. The Interim Final Rule provided guidance on the procedures, limitations and documentation associated with the exemption elections.

Specifically, the rule clarified the conditions under which plan sponsors may exempt non-federal governmental

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On The Front Lines

HIPAA Privacy Rule: Civil sanctions and patient requests

by John E. Steiner, Jr., Esq.

This article discusses two themes emerging in the months following the April 13, 2004 compliance deadline for the HIPAA Privacy Rule.[1] Those two themes are: Privacy Rule civil enforcement and Privacy Rule requests and/or complaints. The first theme is addressed below in a summary discussion of the civil sanction provisions of the Privacy Rule. The second theme is covered below in a less structured manner than the first section. The topic of "patient Privacy requests and complaints" draws on practical examples that covered entities are experiencing in this early phase of HIPAA Privacy compliance. That section also illustrates points of tension that covered entities (especially providers) may be experiencing between patients' satisfaction with the covered entity's responses to their Privacy requests, and legal principles governing the creation and maintenance of medical records. This second theme will, no doubt, continue to unfold across the country as federal and state laws on confidentiality and privacy continue to intersect. Also, as electronic medical records continue to emerge as the dominant record keeping method, the complexity of fact patterns under HIPAA Privacy likely will increase.

HIPAA Privacy Rule: Civil Sanctions and Office for Civil Rights Enforcement Posture

This section highlights key principles related to the civil sanctions under the Privacy Rule.[2] Those sanctions set forth the legal standards against which a covered entity's HIPAA compliance program may be judged. This section does not address whether or how a private party might attempt to use the Privacy Rule standards in a private, civil lawsuit, although the probability exists that such actions may soon be brought by patients. The federal Office for Civil Rights (OCR) is responsible for enforcing the civil sanctions under the Privacy Rule. Statements to date from the OCR reflect the collaborative and conciliatory enforcement approach that OCR has taken with covered entities that can demonstrate "good faith" compliance efforts. From a legal standpoint, the structure of the civil sanctions is fairly straightforward.

Each violation carries a $100 penalty. However, the total amount that may be imposed on a covered entity for all violations of an identical requirement or prohibition during a calendar year is capped at $25,000. Thus, repeated violations can add up to fairly significant monetary penalties, especially for different compliance violations.

Fortunately, the civil sanctions may be mitigated under certain circumstances. A penalty may not be imposed if the covered entity demonstrates, to the satisfaction of the Secretary of Health and Human Services (HHS), that it did not know and, by exercising reasonable diligence, would not have known that it violated a Privacy Rule standard.

Moreover, even if a covered entity did know or, by exercising reasonable diligence would have known, that it would be in violation, it may still avoid a penalty if the failure to comply was not due to "willful neglect," and if the noncompliance is corrected within 30 days. In short, a covered entity may be able to avoid OCR penalties if, after receiving formal notice of a Privacy Rule complaint from OCR, it promptly corrects the situation.

The civil sanctions provide further leeway if HHS determines that the noncompliance occurred because the covered entity was unable to comply. In these circumstances, HHS may provide technical assistance to the covered entity during the 30-day period referenced above. That assistance may be provided in any manner determined appropriate by the Secretary of HHS. Clearly, as our country places more reliance on electronic data transmission, electronic medical records, and sophisticated interfaces between entities that create, process, and transmit protected health information (PHI), the range and complexity of possible HIPAA Privacy Rule violations are likely to increase. This mix of technological evolution and traditional, personal expectations of "confidentiality and privacy" of our health information raises a critical question as to what constitutes "willful neglect" under the Privacy Rule civil sanctions.

Further, under Section 1176 it is possible to reduce a HIPAA Privacy civil monetary penalty. If the covered entity's failure to comply is due to reasonable cause and not to willful neglect, any penalty that is not otherwise mitigated through the steps described above may be reduced to the extent that payment of the penalty would be excessive in relation to Privacy Rule violation.

Given these key points about the government's civil sanctioning authority, it is highly recommended that covered entities take a proactive approach to HIPAA compliance. Several steps that a covered entity can take to defend against an allegation of "willful negelect" should already be part of its HIPAA compliance program, including:

- Develop a Notice of Privacy Practices that is provided to all patients at their first treatment encounter, and is clearly posted in the covered entity.
- Delegate the formal position and duties of the Privacy Officer to a mature and responsible member of the workforce.
- Use reasonable safeguards to keep PHI out of the sight of persons not authorized to see it.
- Distribute written HIPAA Privacy Program policies and procedures to appropriate members of the workforce.
- Adopt methods to monitor and document the monitoring of the use and disclosure of electronic PHI.

These basic steps, among others, should provide a solid foundation for dealing with the OCR in the event of allegations of non-compliance and/or isolated Privacy Rule violations.

Privacy Rule Requests and Complaints from Patients

The Privacy Rule created five federal privacy rights for patients (or their individual representatives). This set of minimum federal standards governs the use or disclosure of a patient's PHI and requires covered entities to adopt formal procedures for handling patient requests related to their HIPAA Privacy rights.[3] Most covered entities probably are experiencing the highest volumes of Privacy requests in two areas: Amendments and Restrictions.

By far, the more complex fact patterns and possible responses by covered entities are to "Amendment" requests. Patients, understandably, expect providers to fully and completely address their requests to correct "clear" errors in their medical records. Such requests usually are handled by the covered entity as "amendment" requests and fall into several categories, including:

1. Incorrectly filed medical records, or portions thereof;
2. Handwriting error;
3. Draft dictation with one or more typographical errors;
4. Substantive error discovered by the covered entity's workforce; and
5. Patient request for a change in the medical record.

Each of these recurring scenarios typically affects the patient's paper and/or electronic medical records. In the first instance, the incorrectly filed document is removed from the incorrect medical record and placed in the correct record without any documentation of that step. In the second scenario, handwritten errors are corrected by striking through the incorrect text, writing "error" above the entry, writing the correct information, and including the initials of the provider authorized to make the correction. This scenario usually occurs almost contemporaneously with the initial entry. Such changes generally are not viewed as substantive. The third situation often is handled by established procedures followed by the provider (e.g., hospital) that allow the reviewing physician to make a change within a relatively short time after the error is identified. This type of change usually does not involve a formal addendum that documents the change. Scenario four arises when health care personnel (e.g., physician, nurse, therapist, medical technician, etc.) identify a substantive error related to a patient's medical condition sometime after the entry was made. This scenario often is identified and handled as a late entry. The fifth fact pattern involves patient requests for changes that are required to be made in writing and processed by a specific department or area (e.g., Patient Complaints, Medical Records, and/or the Privacy Office).

Pre-HIPAA, the letter requests were placed in the correspondence section of the medical record. In many cases, no changes were made to the medical record and the requesting patient was so notified. In cases where a patient's request is granted, nearly always after consultation with the patient's attending physician (and perhaps the patient's referring physician), the change is made following procedures as described in scenario four above. In a post-HIPAA world, patient expectations regarding "amendment" requests often go beyond the remedial steps described above. In short, patients may expect the covered entity to remove any trace of the "error" from his or her paper or electronic medical record. However, the norm for provider covered entities appears to be to follow the options summarized above in lieu of total expungement of an "error" from a medical record.

This overview of the HIPAA enforcement provisions and summary of frequently occurring medical record entry processes highlights several thematic HIPAA Privacy questions:

- How much effort is a covered entity expected to expend in response to patient amendment requests in order not to "wilfully neglect" the patient's Privacy right to request such amendments?
- Which industry standards (such as HL 7) should guide covered entities in the sometimes sensitive and important situations where an "error" relates to a patient's medical condition?
- How far does an individual's privacy right extend vis à vis payors (also "covered entities") if the payor is merely a recipient of erroneous PHI that is in a patient's electronic medical record?

continued on page 7

DOJ official offers advice for avoiding kickbacks in pharmaceutical arena

by Catherine Hubbard, MA, Contributing Editor

Medical institutions that have in-house pharmacies are vulnerable to a broad array of temptations by pharmaceutical companies that want their drugs included on the formulary, temptations that include lavish gifts, free lunches, free drugs and financial kickbacks. It's the job of compliance officers to make sure the bribes don't get out of hand.

Formulary issues. One of the toughest decisions hospitals make is which drugs to include on their formularies. The reality is they can't afford to have every drug from every manufacturer on every formulary, said Justice Department official Jim Sheehan during a Health Care Compliance Association audio conference on pharma and compliance held July 19. "You can't be like Wal-Mart," he said, noting hospitals cannot negotiate the best prices on all drugs and keep every drug in stock. Sheehan is an associate U.S. attorney for civil programs, Eastern District of Pennsylvania.

This reality has led some drug manufacturers' sales representatives to bribe hospital formulary committee members in an effort to get their drugs on the list, Sheehan said. "We see payments and kickbacks to committee members," he said, advising hospitals to consider financial disclosure for members. "It's not an easy decision, but if you're going to have people making significant dollar decisions for patients and the hospital, then it seems you want to have them say from whom they got money and under what circumstances," he advised. He noted that he was expressing his own opinions.

No free lunch. Many health providers have asked department officials whether it's okay to accept meals from pharmaceutical companies, Sheehan noted. While the federal government will not dictate that decision, providers should consider the effect free meals will have on public opinion.

"You have to make the judgement based on what extent you're going to let pharmaceutical manufacturers inside your facility," he said. The decision will be based, also, on the culture of the organization and the face it wants to show the outside world, he said. "The federal government is not going to dictate to you how you're going to do that. That is more a compliance director's call," he said. "The government is not in the business of being the pizza police," he said.

Similarly, Sheehan warned that pharmaceutical companies and device manufacturers might offer unrelated gifts to employed physicians, particularly physicians in research arrangements, those hired as consultants and department heads. "There's the potential for conflict of interest there that needs to be looked at relatively closely in terms of your overall compliance policies," he said.

Sheehan suggested facilities require financial disclosure for physicians. "Physicians will push back, but at the end of the day, you have to look and see what kinds of conflicts exist and what system you put in place to manage them," Sheehan said. He recommended using the "*New York Times* test" with respect to lavish gifts, such as golf tournaments and retreats. "How would they look if they were on the front page of the local newspaper?" he asked.

In one widely reported case, Abbott Labs settled for $622 million last year for providing free tubes and pumps to induce purchases of parenteral and enteral nutrition products. "When you're looking at any type of package you have to decide whether the giving of free goods is intended to increase the purchase of other goods," Sheehan said.

Hospitals also need be careful when accepting free drugs, Sheehan warned. For instance, sometimes a supplier will provide a few free bottles of a drug along with a shipment. "The question is what happens to those bottles," he said. The drugs may end up in the outpatient pharmacy, even though the hospital's contract limits sales of free drugs to inpatient care, for instance.

Also, accepting or asking for bundled drugs, which are groups of drugs that usually include one blockbuster and a few low-worth drugs, raises kickback and antitrust issues, Sheehan said. Providers need to consider when it is appropriate to accept bundled drugs. "When you see bundled drugs, you want to make sure that you have the option of taking them separately," he said.

When legal advice becomes evidence. Although compliance cases focus on the client's actions and intent, they also can involve the lawyer's advice, Sheehan said. "We often find that the advice of lawyer was integral to the transaction," he said.

Once the client invokes the lawyer's advice as the defense to the specific intent of paying a kickback, the lawyer's files, e-mails and conversations are disclosed, he said. "This brings in a whole new group of people as defendants," he said, recommending that employees who work with pharmaceutical manufacturers write down information they receive, upon which their opinion is based.

Moreover, Sheehan cautioned providers against relying on the advice of sales reps, even if that advice is obtained from the reps' lawyer. Even if the manufacturer's rep says the transaction is okay, that advice does not apply to the health care institution, he said. "If you have doubts about a transaction, you should consult your own attorney to find out whether that transaction is okay," he said. "If there is any kickback issue, you need to talk to counsel."

Preventing sales of counterfeit drugs. Pharmacies should make sure expired drugs are destroyed, Sheehan said, advising pharmacies to confirm the drugs are legitimate. In one case, drugs that had been in bottles with proper labels before they had expired were then put in blister packs and given to nursing home patients as single doses. "If you are running a pharmacy, you need to make sure the expired drugs that are picked up are in fact destroyed and you want some kind of commitment and certification by the person who is does the drug destruction that that's happening," he said. He added that the department has seen employees selling expired drugs. "You want to watch your own employees to make sure they are not selling expired drugs out the back door," he said.

Fraud and Abuse (cont.)

To prevent drug counterfeiting, pharmacies and manufacturers should make sure they can trace the lot number and the manufacturing date all the way back, Sheehan said. He noted that counterfeiting arises more often with intravenous drugs, which are usually liquids, and compounded drugs, which are usually created in several different stages and are handled by several people.

Warner Lambert settlement. The Warner Lambert case settled last month "is a hugely significant case," Sheehan said. The company was allegedly encouraging sales representatives to provide on-one-one sales pitches to physicians about off-label uses of Neurontin, a drug to treat epilepsy, including false and misleading information as to Neurontin's efficacy for unapproved uses. "The issue here is how you manage and control your representatives so that they give accurate information," he said, adding that physicians also need to consider accuracy of the information they receive from sales reps.

Some off-label uses physicians approve are benign, especially when they are used for related conditions, such as when a stage four cancer drug is used for stage three cancer, Sheehan said. But some doctors, if they aren't careful, could accept false information from reps and use drugs that harm patients, he said.

The Neurontin case also involved so-called "consultants meetings" for which doctors received a fee for attending expensive dinners or conferences at luxury resorts that included presentations about off-label uses of Neurontin. Sheehan said that at a recent cardiology conference he went to, more than 80 percent responding to an informal poll admitted they've accepted trips to attend conferences for drug manufacturers.

This behavior needs to change, said Sheehan. "We're recognizing a sea change in the industry," he said, noting that both PHRMA and the Health and Human Services Office of Inspector General say physicians should not accept these trips, and advising compliance directors to tell staff physicians and employed physicians they shouldn't accept the trips. "That is where the world is going," he said.

Outlook. Over the next few years, as more and more low-income beneficiaries receive assistance under the Medicare prescription drug card program and as the full drug benefit program becomes effective, the health care system will become even more vulnerable to kickback and other suspicious arrangements, Sheehan predicted. "This is the largest entitlement expansion of the federal health program in the history of the United States," Sheehan said, noting the full drug benefit will cost $50 billion per year beginning in 2006. "We're going to have 40 million Medicare beneficiaries getting drugs paid for by the government."

"Because there's so much money at stake, there's going to be people looking for specific aspects of the system to game," Sheehan said. "We know that that's going to happen." In response to this heightened activity, he said, the DOJ, HHS and the OIG are going to invest increased resources in investigating violations and talking to whistleblowers. "This is a tremendous opportunity for whistleblowers," he said, noting that relaters in the Astra Zeneca case and their attorneys recovered millions of dollars. "The dollars at stake are significant for whistleblowers and their attorneys," he said. ■

CCH Wasbington Bureau, July 27, 2004

HIPAA (cont.)

plans from most of the requirements of Title XXVII of the Public Health Service (PHS) Act. Title XXVII was added to the PHS Act by HIPAA to authorize group market reforms, guaranteed availability of coverage to small group market employers and renewability of coverage to the small and large group markets. The PHS Act further permits non-federal governmental employers to elect to exempt self-funded portions of their group health plans. ■

CCH Chicago Bureau, July 30, 2004

On the Front Lines (cont.)

As Chief Compliance Officer and Privacy Official for the Cleveland Clinic Health System, Mr. Steiner is responsible for the design, implementation and administration of the compliance programs for a multi-state, integrated delivery system that includes an academic medical center. The compliance programs include requirements of government and private payors, clinical research, and HIPAA. His health care expertise includes: health care compliance matters, Medicare, managed care payment and contracting, fraud and abuse, Stark law, False Claims Act matters, tax-exemption, antitrust, JCAHO accreditation, and patient anti-dumping laws.

[1] The federal Privacy standards apply to "covered entities," as defined in 45 CFR Section 160.103, as "health plans," "providers," and "clearinghouses."

[2] 45 CFR Section 160.552.

[3] PHI is defined as "individually identifiable health information" which is transmitted in electronic media, maintained in an electronic medium, or transmitted or maintained in any other form or medium. PHI, however, does not include certain educational records covered by the Family Educational Right and Privacy Act and certain other education-related documents. Under HIPAA, patients have the following rights with regard to their PHI: the right to inspect and obtain a copy their PHI; the right to amend or correct PHI; the right to request restrictions on certain uses and disclosures of PHI; the right to receive PHI through confidential communications; and the right to receive an accounting of certain disclosures of their PHI. 45 CFR Section 164.522.

Hospital to pay $900,000 in overtime back wages

by CCH Editorial Staff

Mt. Clemens General Hospital, Inc, in Mt. Clemens, Michigan, is paying $907,247 in back wages to 2,083 employees resulting from violations to the Fair Labor Standards Act (FLSA). Checks were mailed to employees on July 15, 2004.

Acting on information provided by a U.S. Labor Department investigation, the hospital volunteered to review its time and payroll records for the two-year period from October 2001 to October 2003 under the supervision of the department's Wage and Hour Division office in Detroit. The company's self-audit resulted in the back wage calculation.

"The Department of Labor is committed to ensuring that workers get the wages they're due," said Secretary of Labor Elaine Chao. "The Department has recovered over $900,000 in back wages for these workers. Last year alone, this Administration recovered $212 million in back wages for workers."

The investigation revealed that, when employees started work early or worked beyond their shift, they were not paid for the time unless they worked a full 15 minutes extra. The FLSA allows an employer to round off hours worked, usually to the nearest quarter hour, but such rounding practices must be equally fair to both employer and employee. Rounding practices cannot always result in less pay for employees.

The investigation also disclosed certain technical violations involving the proper calculation of overtime pay when employees receive on-call pay or incentive payments for working an extra shift. Mt. Clemens General also corrected those mistakes, and agreed to pay the back wages.

The FLSA requires payment of the federal minimum wage and generally requires payment of overtime for all hours worked over 40 in a single workweek. Hospitals may pay overtime after 80 hours worked in two weeks, if they also pay overtime after 8 hours worked in a single day. Employers are required to keep an accurate record of all hours worked by their employees.

The 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 recovered 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.

For further information about the FLSA, call the Department of Labor's toll-free help line at 1-866-4USWAGE (1-866-487-9243). Information is also available on the Internet at www.wagehour.dol.gov. ■

CCH Chicago Bureau, July 23, 2004

Three health care companies sued for wage bias, reprisal

by CCH Editorial Staff

Three health care companies—Critical Care Specialist, Inc.; Nurse Associates, LLC; and Advance Nursing Institute, LLC—have been sued by the Equal Employment Opportunity Commission (EEOC) for alleged sex discrimination in compensation. In the lawsuit, the EEOC asserts that the companies violated the Equal Pay Act and Title VII by discriminating against Tammy Joyce Lawrence, Rachel Semenach, Melinda Hoffman and other similarly situated women. The agency also claims that the companies fired Ms. Lawrence after she complained about the unequal pay. The companies operate as an integrated business enterprise headquartered in Greenville, South Carolina. They place nursing and allied health professionals in temporary assignments at facilities throughout the United States. The female employees who were allegedly paid unequal wages worked at the companies' facilities in Greenville and Spartanburg, South Carolina.

The suit (Civil Action No. 6:04-2244) was filed in the US District Court for the District of South Carolina, Greenville Division. In a statement, the EEOC said it filed the suit after exhausting its conciliation efforts to reach a voluntary pre-litigation settlement. The agency is seeking back pay and interest, monetary damages, and injunctive relief prohibiting the companies from engaging in sex discrimination and retaliation.

"Employers are required to pay men and women equal wages for substantially equal work. Furthermore, federal law prohibits employers from retaliating against employees for complaining about discrimination," said Reuben Daniels, Jr., Director of the EEOC's Charlotte District Office. ■

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HIPAA Security Guide

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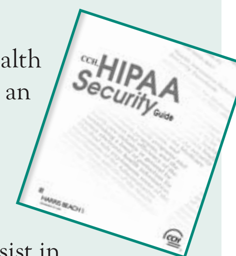

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