Corporate responsibility reflected in hospital criminal conviction

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A not-for-profit community hospital in Western Michigan was found criminally liable for fraudulent activity in a case which is a first of its kind involving corporate responsibility for hospital conduct involving the actions of its medical staff. The indictment, plea agreement and conviction of the hospital is clearly intended by the Federal government to convey the message that corporate health care providers will be held accountable for criminal and civil fraud in the health care industry. The conviction of United Memorial Hospital ("UMH") in Greenville, Michigan is perhaps only the first reflection of the effects of the Enron/Arthur Andersen case and passage of the Sarbanes-Oxley laws and the government's efforts to hold health care corporations, such as hospitals, responsible and accountable for fraud and abuse activity of its employees and agents.

The enforcement of the health care fraud and abuse laws against individuals and organizations is not novel in the health care industry, but the investigation, prosecution and conviction of corporate providers for crimes, whether they be hospitals or other health care facilities and/or profit or not-for-profit entities, is consistent with the Department of Justice's recently announced intentions to hold business organizations subject to criminal charges. *See* Memorandum from Larry D. Thompson, Deputy Attorney General to the Department of Justice Components and the United States Attorneys re: "Principals of Federal Prosecution of Business Organizations", dated January 20, 2003.

The consequences of this increased emphasis on corporate accountability and its ramifications for the health care industry are no better reflected than in the circumstances surrounding the conviction of UMH. The

key factual components of the basis for the conviction of the hospital clearly signal the end of those days when the Board of Directors and Officers of a hospital can afford to act in deliberate ignorance or deliberate disregard of the activities taking place within the corporate organization. This type of corporate accountability for hospitals has also recently been reflected in the announcements of Federal, criminal and civil fraud investigations involving a Tenet health care hospital in California and an HCA hospital in Florida, involving allegations related to the nature and utilization of medical procedures in the hospital's cardiac catherization programs.

The salient facts in the UMH case are instructive and are as follows:

1. The hospital was governed by a Board of Trustees ("Board"), which characteristically had relied upon its medical staff, in particular the Medical Executive Committee ("MEC") and the Professional Activities Committee ("PAC"), to oversee the practices of physicians who have privileges at UMH. The Board, which serves voluntarily, relied upon its administrative management team, particularly the CEO and the CFO, to manage the day-to-day operations of the hospital
2. The MEC and the PAC are accountable to the Board for making decisions about whether to grant, deny, restrict or suspend a physician's privileges and to generally review the physician's practices to ensure the quality of patient care.
3. The hospital was apparently struggling financially in the early '90's and it recruited an anesthesiologist to provide full-time anesthesia services for surgical procedures. This anesthesiologist apparently had no training or specialized experience in pain management, but commenced performing pain management procedures upon arrival at the hospital, which were in addition to the traditional anesthesia services. This doctor was also chairman of the anesthesia department at the hospital and apparently approved his own application

expanding his clinical privileges, to include "management of problems and pain relief".

4. The number of surgical procedures performed by the anesthesiologist rose dramatically from 24 in January of 1994 to 230 in December of that same year. The number and pace for the procedures being performed by this doctor alarmed the operating room medical staff, a number of whom described the situation as an "assembly line" or "mill".
5. The record also reflected that beginning in late 1994 a management team at the hospital began receiving complaints about the anesthesiologist from nurses, operating room staff and ultimately physicians on the medical staff at the hospital.
6. The nurses complaints were numerous and included allegations that the anesthesiologist performed repeated procedures on the same patients, even though the patient showed no improvement; that the anesthesiologist described himself to the medical staff as the "Sam Walton" of pain management; that he freely admitted he was at the hospital to make money and intended to double his "stats" every month; and that he rewrote a poster to read "Quantity over Quality". The nurses also reported that the anesthesiologist often operated on "walk-in" patients, apparently without conducting a history and physical examination to even remotely determine whether the procedure was medically necessary.
7. These complaints were apparently submitted to supervising nurses who were advised by UMH Administration that the anesthesiologist was responsible for generating significant income for the hospital and that they should keep their concerns to themselves or leave the hospital.
8. There were also complaints expressed by physicians on the medical staff who also noted that the anesthesiologist repeated procedures on patients who were apparently not benefiting from those procedures. A physician on staff apparently recommended that the

anesthesiologist not be given expanded pain management privileges.

9. There were apparently also complaints received from patients, one of which advised one of the doctors who was a member of the hospital's PAC that the anesthesiologist admitted doing procedures simply for purposes of increased reimbursement. There was no action taken by that particular doctor or the PAC to investigate this complaint.
10. The Board of the hospital was advised of these concerns about the anesthesiologist as early as May of 1995, but was advised by the CFO that the anesthesiologist's practice "had a favorable financial impact on hospital operations when compared to the budget". The Board, nevertheless, drafted a letter to the PAC directing it to examine the anesthesiologist's practice of using a dorsal column stimulator (a surgically implanted device designed to block pain) and to determine the appropriateness of this procedure at the hospital. The PAC never responded to the Board's inquiry and apparently took no further action.
11. The Chairman of the Board, contemporaneously with this examination, apparently stated at a board meeting that, while the hospital wanted to find someone to review the anesthesiologist's practices, it was important to ensure that it was not someone who would antagonize him or cause him to take his practice to a competitor. The CEO of the hospital had apparently stated during 1996 to a board member that the anesthesiologist's practice constituted approximately one-third of the hospital's income and that "we would not want to hurt him would we?" The revenue for the hospital from 1993 to 1994 increased by nearly $2 million dollars, which is due in large part to income generated by the anesthesiologist's pain management practice.
12. The anesthesiologist apparently also formed joint venture financial relationships with two other doctors on the medical staff of the hospital, one of which was the Chief of Staff

and the other who was the Chief of Emergency Medicine. These three physicians also incorporated "PCS Greenville" with the goal of negotiating with the hospital to increase compensation from the hospital. These doctors continued to sit on committees responsible for reviewing and regulating the anesthesiologist's pain management practice, notwithstanding their mutual financial interests and the recommendation of at least one other doctor that the Chief of Staff and the Chief of Emergency Medicine recuse themselves from review of the anesthesiologist's practices because of a conflict of interest.

13. The proliferation of these complaints apparently had little or no impact on the management of the hospital which did virtually nothing to restrict the number or type of procedures the anesthesiologist was performing over the course of the time period in question and, instead, took actions to discourage complaints against the anesthesiologist. For example, one doctor who continued to voice concerns about the anesthesiologist's practice was told by the then CEO that his comments were not welcome. The same doctor saw his medical referrals dwindle after voicing these concerns and after noting the Chief of Staff and the Chief of Emergency Medicine's financial conflicts of interest regarding the anesthesiologist. The Chief of Staff, acting on behalf of the MEC, in fact, suspended the privileges of one of the doctors who had challenged the anesthesiologist's qualifications to perform continued procedures. Furthermore, the anesthesiologist complained to the then CEO about these doctor's complaints and the CEO shortly thereafter left the hospital to work for the anesthesiologist.
14. An outside medical expert was eventually retained by the hospital to review the medical necessity of the anesthesiologist's surgical procedures. This expert reported that he was unable to render such an opinion, given the lack of medical documentation in the

anesthesiologist's files. However, the PAC took no action for eight months and when it did only counseled the anesthesiologist to improve the documentation of his work. The anesthesiologist, in fact, continued to perform pain management procedures at the hospital in an unrestricted fashion up until August of 1996 when he voluntarily resigned from the medical staff after meeting with the Board's attorney.

15. The Board eventually submitted eighty patient charts from the anesthesiologist's files to the Peer Review Organization of Michigan ("PROM") after the death of one of the anesthesiologist's patients. The PROM issued a report in November of 1996 (three months after the anesthesiologist left the hospital), noting the following:

> "There were several themes that were recurred in the records examined: Specifically, the evaluative process presented was uniformly inadequate. Results of the testing data, and findings either within history or on physical examination that supported the purported diagnostic impressions were consistently absent. There was an apparent routine over use of invasive techniques without clear indications. The Pain Management activities seemed to have proceeded without evidence or [Sic] efficacy, quality assurance or outcome evaluation…Continuing to allow invasive procedures without objective evidence of improvement in pain level, narcotic use, functional improvement or return to work is not warranted."

16. The hospital continued for several more years after this report from the PROM to collect fees generated by the procedures performed by the anesthesiologist, including fees for services performed on the patient who died. There was no effort on the part of the hospital to quantify the extent to which the medically unnecessary procedures resulted in the receipt of

> unauthorized revenue from Federal health programs and/or third-party commercial payors, let alone return such overpayments.

The developments in this case could be a harbinger of things to come as corporate responsibility and accountability assert its place even more profoundly in the health care industry. The underlying basis for commission of a corporate crime is, of course, imbedded in the collective and aggregate activities of individuals who are representatives and agents of the corporation. The hospital was not the only party convicted of a crime in this case. The case also included conviction of the Chief of Staff and the Chief of Emergency Medicine on state misdemeanor charges of aiding and abetting larceny. The anesthesiologist was convicted of thirty-three counts of mail fraud after a two-week trial, including allegations of the performance of unnecessary procedures at UMH. The former CEO at the hospital is still facing charges in a related case, including three counts of perjury before a Grand Jury concerning his involvement with contractual negotiations between the hospital and the anesthesiologist.

The conviction of the hospital of a crime raised the issue of whether or not it would be subject to mandatory exclusion from Federal health programs. The United States Attorney's press release in the case, in fact, stated that if the hospital were to have been convicted at trial, it would have been subject to mandatory exclusion from the Medicare and Medicaid programs. The hospital's plea agreement includes a stipulation that the plea will be suspended by the court while the hospital serves a three year probationary period during which time it will be subject to an obligation to implement a compliance program designed to ensure that it will comply with all Federal and state laws and that its coding and billing practices will be audited on an annual basis. This type of sentence ordinarily would not, by itself, fall outside the definition of "conviction" for purposes of application of the mandatory exclusion authority under Federal health care programs. However, the plea agreement to a count of wire fraud against private payor programs, <u>is</u> <u>not</u> one of the categories for mandatory exclusion, which only relate to convictions involving Federal health care program (Medicare and Medicaid) related crimes; convictions

involving abuse and neglect of a patient; convictions involving controlled substances and convictions involving financial misconduct in other Federal health programs. Furthermore, the Office of Inspector General of Health and Human Services ordinarily does not impose mandatory exclusion as a practical matter until after sentencing in a case. The sentence in this case has not been entered and will not be entered (and in fact the case will be dismissed) as long as the hospital successfully completes the three-year probationary terms under the plea agreement.