

Nursing: ha-353 legal aspects healthcare administration report sample

[Law](#), [Criminal Justice](#)



Issues for Healthcare Organizations

Lesson 3: 1- Antitrust

Lesson 3: 2 - Health Information Management

Lesson 3: 3 - Fraud, Abuse, and Corporate Compliance

Abstract

This document contains answers to lessons 3 units 1, 2, 3 pertaining to Issues for Healthcare Organizations. Unit 1 explores antitrust management; unit 2 - Health Information Management and unit 3 Fraud, Abuse, and Corporate Compliance.

Issues for Healthcare Organizations

Lesson 3: 1- Antitrust

Question 1: Antitrust regulations - Sherman and Clayton Acts

- Mergers, consolidations and acquisition components of Sherman and Clayton antitrust acts like any other corporate legal intervention endorses regulations regarding purchasing; selling, dividing and combining with other companies that offer different or similar products and services. The alignment is to encourage enterprise growth and development within merging health care institutions (Cseres, 2005).

Considerations regarding application of regulations in both Clayton and Sherman Acts pertain to acknowledging that these acts are designed for capturing anticompetitive practices within health care institutions and address them immediately. Four main principles are considered. First, pricing discriminatory practices; fairness in sales transactions; merger and

acquisition that would not hinder competition and preventing directors from holding such positions with more than one company at the same time (Cseres, 2005).

- Considerations regarding price setting, price control, competitive bidding for contracts, goods, or services embody a series of legislations outlined in both Sherman and Clayton Acts. A major consideration for all participating health care organizations is acknowledging that these acts were meant to protect consumers of health care and not providers of services. The main goal is to control price setting and prevent monopoly of any kind within the health care setting (Cseres, 2005).

Price discrimination or price differentiation occurs when sales of same goods or services are carrying different prices by the same provider. Theoretically, this can be interpreted as monopolistic behavior, for which both Clayton and Sherman acts prohibits. However, when product heterogeneity exists and market frictions impose high fixed costs a small degree of differential pricing to different consumers, in fully competitive retail or industrial markets are allowed (Frank, 2010).

Also when applying the Clayton and Sherman Act in health care settings other considerations encompass understanding the role U. S. Justice Department and the Federal Trade Commission (FTC) play in deciding ' when, where, and how competition has been violated by health care provider organizations, insurers in managed care organizations, group purchasing plans, and vendors' (Study Notes, Lesson 3: 1, 2013). Precisely, Federal Trade Commission is actively engaged in reviewing relationships among health care organizations that enhance competitions or monopoly practices

to intervene before it reaches the consumer (Study Notes, Lesson 3: 1, 2013).

- Considerations of trustees in determining medical staff privileges pertain primarily, to adherence of Federal Trade Commission regulations regarding this intervention within health care administration. According to the legal implications established under Clayton and Sherman Acts being supported by FTC, a trustee is someone who has authority to own assets apart from one person entrusting his/her property to another. In this particular case the asset is possessing authority of executing medical staff privileges. However, within considerations of preventing exploitation of the consumer with medical staff being consumers in this sense there are limitations to trustees' authority.

Peter J. Hammer and William M. Sage (2003) advanced that 'from an economic perspective, the modern hospital can be seen as organizing the production of medical services, using physician labor as both a supply input and a distribution network to patients.. few physicians would accept this description' (Hammer & Sage, 2003, pp 90).

Importantly, both physician labor and patients are assets, which antitrust articulate for benefit to the public sector and not private according to these analysts. Therefore, organizations must limit this manipulation of trustees' impact on medical staff privileges through organizing themselves into organizations that would represent rights of professional bodies and recruiting agencies (Hammer & Sage, 2003).

Question 11: Dr. Will versus Sherman Antitrust Act

Sections 1 and 2 of Sherman Act read:-

Section 1

" Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."

(Cseres, 2005, pp 70).

Section 2:

" Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felon." (Cseres, 2005, pp 70).

For a tort claim to be valid there must be an expectation based on verbal, or non-verbal agreement, the expectation must be violated; the violation must create harm to the individual deserving compensation. To file a claim based on Section 1 of Sherman's Act Dr. Will must show evidence of a conspiracy to deprive him of medical privileges. For section 11 he will have to prove that the trust entity was trying to monopolize the transaction based on a plot of conspiracy. Sherman's Act has been modified for use in specific health care settings, which stipulate how relationships are to be organized among entities that adhere to contract rules (Cseres, 2005).

Exclusive contract may appear to be a violation since it can promote monopolizing the product. However, if the action was executed within consumers' interest then there was no conspiracy and Dr. Will cannot win his

case. Modern trends related to law suits brought against companies claiming violations of Sherman's Act show where plaintiffs find difficulty in providing evidence of conspiracy it was not clear whether the conspiracy was conceivable or implied. Hence, Dr. Will has a very unpredictable case should he attempt to file a law suit (Cseres, 2005).

Lesson 3: 2 - Health Information Management

Question 1: Medical Records

- Three ways medical records could be used in court is to support evidence; acquit an accused and provide treatment verification. Precisely, this is the reason for promoting accurate medical recording keeping despite challenges met with balancing concerns for patient confidentiality and access requirements to health information. This is a costly endeavor, but in an era of accusation of medical malpractice this is the only evidence courts, plaintiffs and defendants have in supporting their case (Study Notes: Lesson 3: 2, 2013).

Further constraints relate to establishing an accountability frame work balance between health care services and the cost incurred in ensuring accurate documentation for legal purposes. It includes complying with government and business regulations for access to patients' records in litigation as well as budgeting to marketing applications (Study notes Lesson 3: 2, 2013).

- According to HIPAA and organization policy there are ways that medical records could be disclosed without a patient consent's. They include cases where there is public health surveillance of a disease; health organizations

are obligated to forward records for epidemiological analysis. Information regarding substance abuse; domestic violence can be tendered to law enforcement without a patient's consent. Also in cases of mental illnesses when patients are uncontrollable and law enforcement or courts have to intervene their records can be tendered without former consent in public interest (Study notes Lesson 3: 2, 2013).

Usually, Office for Civil Rights is the enforcing agency responsible for HIPAA Privacy Rule execution. Privacy protection of identifiable individual health information is its goal. This HIPAA Security Rule also establishes national security standards pertaining to how electronic records are protected within the health information system network. Confidentiality provisions of the Patient Safety Rule are inclusive within these legislations. Insidiously these legislations protect identifiable information which is ultimately used to analyze patient safety issues in efforts to improve the delivery of health care practices (Health Information Privacy, 2013).

- Some regulatory protections regarding privacy that are required of providers and health plans by HIPAA include allowing patients' access to a copy of their medical record; request that any mistakes corrected; receive notice concerning how personal health information is used and shared; request the terms under which the patient is contacted by their health care provider; and file a complaint if in anyway the patient feels that his/her rights to privacy have been violated (Health Information Privacy, 2013).

Meanwhile, the Health Insurance Portability and Accountability Act (HIPAA) provide rights and protections for participants and beneficiaries in group

health plans. HIPPA protections excludes health plans from limiting persons with preexisting conditions from enroll; prevents discrimination based on an employee or dependents' health status. Special provisions must be made enrollment in a new plan if the individual no longer feels comfortable with existing conditions of the present plan. Information tendered for enrolment is protected from sharing except with consent of the patient (Health Information Privacy, 2013).

- Obligations regarding the storage and disposal of paper and electronic medical records are imposed by HIPAA. Organizations are directed to implement strategies compatible with the technology in their particular settings for safely storing disposing of both electronic and hand written records when they are no longer needed or have to be stored. However, this must be executed within the confines of HIPPA regulations. Specific disposal procedures include burning, shredding, pulverizing, pulping to render them indecipherable, unreadable and difficult to be reconstructed (The HIPPA Privacy Security Rules, 2013).

Further storage/disposal measures include keeping labeled prescription bottles and other patient health information away from places accessible to visitors. Precisely, they should be held in opaque bags in a secured part of the facility. In ensuring total safety in the disposal process a disposal vendor can be contracted to removed patient health information to a terminal site where it can be fully destroyed, Some organizations use a disposal software to remove unwanted data (The HIPPA Privacy Security Rules, 2013).

Question 2: Case Study 12 year old pregnant mother

Step 1: Identify Facts

- I am the hospital administrator
- Mother of a 12 year old pregnant minor seeks to obtain medical records
- Mother wishes to identify whether child disclosed the father of infant identity
- Patient is unmarried and lives with parents
- Parents are paying for obstetric care
- Patient does not consent to release of records
- Mother threatens to sue hospital

Step 2: Identify legal issues

- The pregnant patient is a minor.
- The pregnancy ought to be fully investigated to rule out incest/rape.
- The patient is not eligible to give consent for sexual intercourse.
- The patient is not eligible to refuse release of records if requested by a parent who is also the legal guardian.

Step 3: Elaboration of legal issue

This child is a minor, which make it ineligible for her to refuse consent in release of records to a parent. However, this parent has to show the court or hospital administrator that he/she has legal custody of the pregnant child. Even though the child lives with the parent and her mother pays the hospital bills it does not automatically make the mother eligible to view medical records unless she proves legal custody of the child. Perhaps, she may have

to move to the court regarding obtaining a court order showing legal custody before trying to fight a law suit against the hospital.

Step 4:

- The parent provides the consent for treating the pregnant minor if under parental custody; otherwise the legal guardian
- This would be consistent with the requirement posed by HIPPA it is just that the parent or legal guardian has to prove legitimacy to the records.
- I would provide the records to the mother after she proves to be the legal guardian since the child is a minor.
- The other legal issue involves a pregnant 12 year old who cannot give consent for sexual intercourse. The father is not being disclosed.
- With consent of the parent hospital social services could contact the police to launch an investigation into the incident.

(The HIPPA Privacy Security Rules, 2013).

Lesson 3: 3 - Fraud, Abuse, and Corporate Compliance

Question 1: Corporate Compliance Program

Corporate Compliance Programs (CCP) could be synonymous to Accountable Care Organizations (ACO) as it relates to health care providers relationship integrity with clients and each other. The corporate Compliance Program forces transparency with organizations in an effort to reduce fraud and limit abuse (Study Notes: Lesson 3: 3, 2013).

The goal is offering public assurance of the organization's compliance with regulations and laws designed to detect professional misconduct in transactions within the company's polices. These strategies revolve around

self-auditing and self-policing, voluntary disclosure of violations and bringing to justice perpetrators of consistent fraudulent practices (Study Notes: Lesson 3: 3, 2013).

Five important components which are valuable elements in detecting irregularities are designing a Code of Conduct for employees and one for contractors/vendors; creating a Compliance Committee; establishing a confidential reporting hotline; investigating all items brought to awareness and implementing remediation through action planning aimed at preventing reoccurrence and frequency of issues that arise from time to time (Study Notes: Lesson 3: 3, 2013).

In designing a Code of Conduct for employees and one for contractors/vendors my first step would be to conduct an audit within the organization identifying common irregularities in budgeting; financial conduct and contractor/vendor relationships. Data collected from this process will be taken to management for review and a remedial code of conduct to be designed. Next, in order for the code to be considered serious a compliance committee will monitor its effectiveness and adherence over time to evaluate if employees as well as management are making efforts to remedy their actions to be in alignment with the code.

Thirdly, is creating a safe space through transparency by encouraging a confidential reporting line. A fraud hotline will be set up with 24/7 access to the public for reporting suspicious transactions. This gets the public involved in scrutinizing irregularities and reporting them to management. It also initiates awareness that someone is watching and will tell. Confidentiality will primarily protect the person reporting and not exposure of the irregularity.

For each item reported the compliance committee will analyze as pertinent data; investigate and report findings to management. Every six months a task force will review reports from the compliance committee; a planning committee will meet with the board to review existing remedial plans and make adjustments.

Question 2: News Paper Article

Largest US Hospice Company sued for Medicare fraud by Kelli Kennedy
(Miami Herald 9th May, 2013)

According to this news article Florida Department of Justice is suing a hospice company founded by Florida senate president for millions of fraudulent claims tendered to receive Medicare reimbursements. Facts related to the incident are that Vitas Hospice and Vitas Healthcare submitted claims for emergency services, which were not necessary apart from not being provided (Kennedy, 2013).

Besides, Florida Department of Justice discovered that services were provided to ineligible patients and forms were still submitted. Importantly, these companies claimed crisis-care days which were to be billed after pressuring employees to submit additional claims to improve their revenue. Crisis care according to Medicare managed care consultants can amount to far more dollars than actual hospice care for which these agencies are legitimately required to offer (Kennedy, 2013).

Vitas is the largest US chain for hospice care. Chemed Corp is the parent company for Vistas. However, current vice president of the board, Don Gaetz, claims his innocence by denying any knowledge of the transactions.

He claims that even though the company was founded by him he was an inactive board member for 13 years simply participating as a shareholder. The legal issue pertains to The Justice Department claims that Medicare reimburses hospice care for terminal patients who are expected to die within six months. Treatment is limited to pain management and emotional support. Crisis care is not included in hospice treatment and is far more costly. Consequently it would appear to be a deliberate attempt by Vistas to defraud the government (Kennedy, 2013). An effective Corporate Compliance Program could have detected the irregularity; have it investigated, reported and remedied before escalating to a lawsuit.

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