

# OIG allows discharge of indigent patients after dialysis care

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IN ITS FIRST ADVISORY OPINION FOR 2007, the Department of Health and Human Services, Office of the Inspector General, allowed a large public health system (with a statutory obligation to provide health care to all citizens) to admit indigent chronic dialysis patients for dialysis treatments three times a week; and immediately discharge them following each treatment.

Prior to this advisory opinion, the hospital would admit indigent patients requiring chronic dialysis treatments to the hospital and maintain them as inpatients until an outpatient dialysis chair in the community was secured. During the interim, these patients essentially lived in the hospital. The patients typically were individuals who had Medicare or Medicaid applications pending or who suffered from psychiatric conditions that made an outpatient setting inappropriate.

Consistent with its statutory obligation, the hospital did not charge these indigent patients; the hospital's care was designed solely to bridge the gap in care before a patient could secure an outpatient dialysis chair. However, these chronic dialysis patients reduced the available number of beds for otherwise paying patients. Also, patients in the emergency department would often have to wait for an inpatient bed to become available. In turn, this caused the emergency department to reach capacity, diverting patients to other emergency rooms.

Given this chain reaction of delays, interruptions and lost revenue, the hos-

pital sought permission to admit and discharge chronic dialysis patients to the hospital three times per week. Essentially, the hospital sought to offer in-hospital chronic dialysis treatments in an acute setting until a chronic patient could secure an outpatient dialysis chair. This request presented several regulatory concerns, particularly the prohibition against inducements to beneficiaries. The OIG acknowledged the regulatory concerns, but declined to take action against the hospital.

The OIG based its decision on, among other factors, that:

- ▶ The hospital would not bill these patients or any third party payer, including Medicare or Medicaid, for these admissions.
- ▶ The hospital would not advertise the availability of these services.
- ▶ The hospital's renal case manager/social worker would assist any chronic dialysis patients who became eligible for Medicare or Medicaid to find an outpatient dialysis chair in the community.
- ▶ Although the hospital operated an inpatient dialysis unit, it did not offer outpatient dialysis services and therefore Medicare and Medicaid beneficiaries treated under the proposed arrangement would not return to the hospital for such services.

The OIG concluded the dialysis treatments constituted remuneration to the patient who received them—a key concern in any regulatory analysis. However, it found that it was unlikely that the free

treatments would influence patients to select the hospital for current or future services. Important to the OIG's findings, the hospital did not offer outpatient dialysis services and the hospital worked to locate an available outpatient chair once any patient became eligible for Medicare or Medicaid. As a result, in the OIG's view, the patients were unlikely to continue to rely on the hospital for care. Also, the OIG determined that any generalized feeling of goodwill towards the hospital that could potentially influence these patients to choose the hospital for non-dialysis services in the future was too speculative and attenuated.

This advisory opinion applies only to the hospital in question and the findings were very fact-specific. Also, there are many unanswered questions surrounding this advisory opinion. For example, it declines to comment upon the arrangement between the hospital and the management company that operated the dialysis unit on behalf of the hospital. The hospital certified that it paid the management company fair market value for the services it rendered to these chronic dialysis patients and the management company did not bill anyone for the services. However, the fact that the OIG could potentially scrutinize the fair market value of any management agreement and the potential referrals arising from the hospital to the outpatient facilities was not addressed.

This advisory opinion decision is heavily reliant upon the facts and circumstances of this particular hospital's operations and its patient population. Any hospital facing similar problems should review very carefully its specific situation and consult experienced counsel before exploring a similar strategy, as it is not without regulatory risks. ♦



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