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**AMERICAN HEALTH LAWYERS ASSOCIATION**

**Year in Review 2003-2004**

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OVERVIEW
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The year preceding June 30, 2004, has been one of the most active periods in the development of health policy and health law in a generation. Against the odds, President Bush delivered on his promise of a prescription drug benefit for Medicare beneficiaries. As with all momentous legislation, the prescription drug benefit was accompanied by legislative changes, both large and small, affecting virtually every sector of the healthcare community. In addition to new legislation, the Bush administration continued to release regulations deemed vitally important by those regulated. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) pursued new standards and processes to improve patient safety, and the courts dealt with myriad health law issues.

The Year in Review begins with a “Top Ten” list of some of the year’s most noteworthy developments. This obviously subjective collection has been culled from a much larger universe of cases and administrative and legislative events that occurred during the past twelve months. It is the author’s belief, however, that it fairly represents the range of significant new issues facing Health Lawyers’ members.

The Top Ten


On December 8, 2003, the President signed Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This historic legislation, supported by a large majority of Republicans and opposed by many Democrats, is the largest expansion of the Medicare program since its inception. The bill became law after the House leadership held open the floor vote for an unprecedented three hours, with legislators complaining of dislocated elbows the next day. Administration actuaries believe that the legislation, estimated to cost $495 billion over ten years at the time it was signed, will be far more costly than estimated.

Allegations of stifled administration cost estimates, as well as House floor arm-twisting, have spawned divisive congressional investigations. If political import can be measured by post-passage allegations of wrongdoing, this legislation packs a strong political punch.

The MMA adds a new prescription drug benefit for Medicare beneficiaries that will become effective in January 2006. Until the effective date, the Department of Health and Human Services (DHHS) will make a prescription drug discount card available to beneficiaries.
The new law replaces the Medicare+Choice program with an expanded managed care program called Medicare Advantage. The new program is intended to increase reimbursement to Medicare managed care plans, and the Centers for Medicare and Medicaid Services (CMS) acted quickly on that promise by promulgating a 10.6% increase for such providers within six weeks of the law’s enactment.

The MMA also enacts myriad reimbursement adjustments (many of them enhancements) and regulatory changes for a diverse set of Medicare providers.

2. Clarifying EMTALA

On September 9, 2003, CMS issued a final rule clarifying hospital obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA). This Act obligates hospitals and physicians to provide those presenting in the emergency department a medical screening examination, as well as necessary stabilizing treatment or appropriate transfer. The final rule was generally well-received by the healthcare community in that it consciously attempted to balance a hospital’s and physician’s duty to examine and treat patients with the practical realities of operating hospitals and medical staffs.

Specifically, the final rule clarified the actions that hospitals and physicians may take in registering emergency patients, including inquiries into whether an individual has insurance. The rule re-emphasizes that such inquiries may not delay the screening or treatment required by EMTALA. The rule permits emergency room physicians to seek information from a patient’s regular physician at any time if the information is relevant and does not inappropriately delay the screening or stabilization. The final rule adopts a “prudent layperson” standard, so that the obligations of EMTALA are triggered when an individual presents at the emergency room and a prudent layperson observer would believe that the individual needs examination or treatment for a medical condition. In the rule, CMS consciously attempts to provide flexibility to hospitals in complying with EMTALA’s requirement that hospitals maintain an on-call roster.

The final rule explains the statutory phrase “comes to the emergency department,” clarifying providers’ obligations when a patient presents at a dedicated emergency department or at another part of the hospital, including at off-site facilities. CMS also attempted to clarify confusion in the law and the courts regarding when EMTALA’s obligations apply to inpatients. The rule states that EMTALA’s obligations cease when a patient is admitted for inpatient care. The final rule also addresses when EMTALA obligations apply to hospital owned ambulances.
While the statute and its regulations continue to have ambiguity, the healthcare community was generally pleased with CMS’ balancing of patient/provider interests.

3. The Great Reimportation Debate

States, struggling under the dual pressures of rising Medicaid costs and cash-strapped constituents, looked hopefully to the north for less-expensive prescription drugs. Governor Rod Blagojevich commissioned a study finding that Illinois workers and retirees would realize a combined savings of over $90 million annually by allowing prescription drug purchases from Canada.

In the MMA, Congress gave with one hand while taking with the other. A newly created § 804 of the Food, Drug, and Cosmetic Act requires the Secretary of Health and Human Services (Secretary) to promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada. The same section, however, states that the provision will not become effective until the Secretary certifies that it will “pose no additional risk to the public’s health and safety.” Because of the Secretary’s reluctance to make such a certification, the provision effectively kills reimportation.

On March 16, 2004, the President appointed Surgeon General Richard Carmona to head up a Drug Importation Task Force to study how to import drugs safely and determine the impact on medical costs and patient care.

Members of Congress are caught in between their constituents and the administration. On April 21, 2004, Senator Byron Dorgan, with an impressively bipartisan list of cosponsors, introduced S. 2328, the Pharmaceutical Market Access and Drug Safety Act. The legislation provides statutory safety protections for consumers of imported drugs, but does not require Food and Drug Administration certification prior to importation.

4. Putting the Finishing Touches on Stark II

On March 26, 2004, CMS issued the second phase of its final regulations interpreting the expanded federal physician self-referral ban, commonly known as Stark II. The regulations enforcing Stark II have been long in coming because of the enormous difficulty in applying the statute to the complex relationships, many of which are legitimate, that characterize the healthcare marketplace today. Health Lawyers’ experts gave CMS credit for these regulations, stating that “the regulations reflect the diligent efforts of CMS to listen to providers and to implement the Stark Law in a realistic manner.”
The Phase II rules introduce a number of new exceptions, clarify the definitions of “set in advance” and “indirect compensation arrangement,” modify the physician recruitment exception, eliminate many reporting requirements, and clarify the “one-year term” requirement. For attorneys providing compliance advice on transactions and operations, the promulgation of these rules was certainly one of the most significant developments of the past year.

5. Upping the Ante on Antitrust Enforcement

Over the past eighteen months, the federal enforcers of antitrust law have retooled and reenergized their enforcement efforts. Between February and October 2003, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) held a series of hearings entitled Health Care and Competition Law and Policy. These hearings, and the continued aggressiveness of the agencies in prosecuting enforcement actions, caused antitrust enforcement to reach into the Top Ten developments of the past year.

The hearings explored many of today’s cutting edge issues in healthcare antitrust enforcement, including the definition of a hospital’s product and geographic markets, the impact of specialty hospitals, alleged “tying” by networks, the impact of failed enforcement actions against hospital mergers, an examination of the post-merger conduct of those merged entities, monopsony concerns of providers regarding the health insurance market, the definition of product and geographic markets for physicians, group purchasing organizations, and remedies.

The hearings are expected to generate a comprehensive report by FTC/DOJ sometime this summer that will provide meaningful guidance to the healthcare community on the enforcement agencies’ views on antitrust enforcement.

In 2002, the FTC admitted that its strategy for challenging mergers in the 1980s and 90s was no longer successful and announced that it would examine the results of mergers to determine whether administrative action should be taken to challenge them retrospectively. On February 10, 2004, the FTC announced that it was initiating such a challenge by filing In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc. In its complaint, the FTC claimed that the 2000 merger of Evanston Northwestern Healthcare Corporation and Highland Park Hospital had resulted in higher prices and violations of § 7 of the Clayton Act and § 5 of the Federal Trade Commission Act.

6. Physicians and Hospitals Clash over Specialty Hospitals

An important theme over the last twelve months has been the rising tension between hospitals and physicians in the provision of healthcare. No activity
typifies that antagonism more than the passage of a moratorium on the construction of "specialty hospitals" that was included in the MMA.³⁴

The conflict between physicians and hospitals has numerous ongoing causes, but one significant factor has been an erosion in physicians’ income and an increase in their expenses. The combination has caused physicians to seek innovative ways to earn ancillary income, including the ownership of healthcare facilities. Yet, the income earned in this manner comes at the expense of the general hospitals where those procedures would have been performed.³⁵

After a significant legislative battle between physicians and hospitals, Congress legislated a compromise. The MMA excludes “specialty hospitals” for eighteen months from the “whole hospital” exception under the Physician Self-Referral Law, effectively forbidding physicians from referring patients to “specialty hospitals” in which the physicians have an ownership or financial interest.³⁶ This moratorium is not an all-out ban forever, but it gave general hospitals a short-term victory.

Following passage of the law, CMS issued a transmittal on March 19, 2004, expanding on the terms and definitions contained in the original legislation.³⁷ The transmittal defined a “specialty hospital” as one primarily engaged in the treatment of patients receiving surgery or with a cardiac or an orthopedic condition.³⁸ The legislation had grandfathered specialty hospitals that were in operation or “under development” as of November 18, 2003, and the guidance elaborated on the definition of those terms.

To demonstrate the ferocity of the debate, HCA announced that it would notify authorities when it identifies planned surgical hospitals that may not qualify under the grandfather clause contained in the new law.³⁹

7. The Elusive, Evolving ERISA

The courts continue to struggle with suits by healthcare consumers regarding allegations that managed care plans’ coverage decisions adversely affect the quality of care received. Since the U.S. Supreme Court’s decisions in Pegram v. Herdrich⁴⁰ and Rush Prudential HMO v. Moran,⁴¹ courts have struggled with the difference between coverage decisions governed by remedies under the Employee Retirement Income and Security Act (ERISA) and the medical judgment used to make coverage decisions, for which some states, like Texas, have created state causes of action.⁴²

This term, the Supreme Court granted certiorari in two cases designed to provide needed clarity to the debate over whether a health plan’s medical necessity determinations can subject it to negligence causes of action in state court.⁴³ Those representing Aetna and CIGNA in the consolidated cases
argued that state law governs physicians who exercise medical judgment in providing care, while ERISA’s federal remedies govern plans that administer the payment of claims for that medical care. Counsel for patients argued that the state legislature in Texas had the discretion to fashion medical malpractice laws to protect its state’s citizens from medical negligence, and that Aetna and CIGNA’s utilization review shaped the care received by patients and subjected the plans to state remedies fashioned in the 1997 Texas Health Care Liability Act.

The Supreme Court will hand down a decision in June that hopefully will provide more clarity to this murky area of the law. Since medical personnel at health plans do exercise medical judgment in making determinations about medical necessity and coverage decisions, their actions have been scrutinized by consumers, their attorneys, and by state legislatures. Hopefully, the Supreme Court can provide more guidance on distinguishing between permissible state penalties for negligence and permissible federal remedies for coverage decisions.

8. Abortion and Privacy: The Rules of Discovery

On November 5, 2003, President Bush signed into law the Partial Birth Abortion Act of 2003. The American Civil Liberties Union and other plaintiffs immediately filed lawsuits to enjoin enforcement, arguing that the law is unconstitutional because it does not have an exception to protect the health of the mother. A federal district court in Nebraska issued a temporary restraining order soon after the bill was signed into law. A California federal district court permanently enjoined enforcement of the law as unconstitutional on June 1, 2004.

In defending the statute against three challenges in Nebraska, California, and New York, the Justice Department subpoenaed the records of women in California, New York, and Chicago who had undergone the dilation and extraction abortion procedure that is banned by the new law. The Justice Department argued that it needed the records to demonstrate the procedure was not medically necessary and therefore a health exception was unnecessary. The Department asserted that it would take steps to protect the patients’ privacy. Those opposing the subpoenas argued that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy laws protected the medical records of the women who had undergone the procedures. District courts in different cities came to different conclusions, with the New York court requiring compliance and the Chicago court quashing the subpoenas.

stated that the Justice Department withdrew its request for the records because of an important public interest in resolving the issue quickly.51

This issue ranks in the Top Ten because of the clash of privacy interests at the core of the debate, and the significance of the suits challenging the constitutionality of this new law.

9. To Discount or Not to Discount, That Is the Question

Over the last twelve months, advocates for the uninsured have begun to voice displeasure at being one of the only groups to pay full-billed charges for hospital care.52 In reaction to the rather successful public relations campaign of Consejo de Latinos Unidos and other advocacy groups, the House Committee on Energy and Commerce began an investigation of health systems’ charges to the uninsured by requesting detailed information from twenty major hospital systems.53

The American Hospital Association (AHA) sent a letter on December 16, 2003, to the Secretary of Health and Human Services, in which the Association argued that federal law and regulations make it difficult for hospitals to discount charges for the uninsured: "[F]ederal Medicare regulations as written today contain a string of barriers that discourage hospitals from reducing charges or forgiving debt for these patients without potentially running afoul of the law."54 The AHA believed that the federal Anti-Kickback Statute, bad-debt reimbursement regulations, and a statute that allows exclusion of providers that bill Medicare more than their usual charges impede this form of discounting.55

On February 19, 2004, Secretary Thompson informed AHA that he believes that discounts to the uninsured are permissible: “Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay ‘full price’ for their care. That suggestion is not correct and certainly does not accurately reflect my policy.”56 He enclosed clarifying materials from CMS and the OIG with his letter.

After the release of Secretary Thompson’s letter, Tenet Healthcare announced that it would implement discount pricing for uninsured patients at all of its hospitals except those in Texas, believing that Texas law prohibits it.57 This issue will remain of intense interest to providers and consumers over the next twelve months as well.

10. Who Controls the Joint Venture?

The last twelve months have been important in the debate over joint ventures between tax-exempt and taxable entities. On November 7, 2003, the Fifth
Circuit reversed the District Court in *St. David’s Health Care System v. United States*, finding that the Internal Revenue Service’s (IRS) decision to revoke St. David’s tax-exempt status should proceed to trial. The district court had fashioned an extremely flexible approach to determining whether a nonprofit retains sufficient control over a whole hospital joint venture to preserve its nonprofit status.

The appeals court did not find the flexible approach of the district court persuasive and instead found that the indicia of control suggested by St. David’s did not as a matter of law provide the nonprofit sufficient control of the joint venture. The appellate court found significant factual issues that would be appropriately resolved at trial and would be determinative of the control issue. On remand, a jury found that St. David’s should retain its exempt status, dealing the government a significant loss on the issue of control in joint ventures.

On May 6, 2004, the IRS released Revenue Ruling 2004-51, finding that a tax-exempt university maintains its tax-exempt status when it contributes an insubstantial part of its assets to an ancillary joint venture with a for-profit company that specializes in conducting interactive video training programs. The IRS cited *St. David’s* and addressed favorably some of the control issues that it found wanting in the *St. David’s* case.

**Practice Group Analyses**

**Antitrust**

As observed earlier, the FTC and DOJ have focused their resources on antitrust investigations and enforcement over the last twelve months. In October, the two departments concluded eight months of hearings related to healthcare competition law and policy.

The FTC continued its enforcement focus on the pharmaceutical industry and on fee negotiations through allegedly defective messenger models. In *Schering Plough Corp.*, the full FTC held that agreements between Schering Plough and two generic manufacturers settling a patent infringement suit constituted an unlawful market allocation agreement. The Eleventh Circuit struggled with the legal standard to apply in such cases when it held that the district court should apply the rule of reason to a case in which Abbot settled a patent infringement suit against Geneva and Zeneca by limiting the entry of new products in exchange for a substantial payment.

The FTC entered into a number of consent decrees this past year that disciplined “messengers” for using illegal means to negotiate fees with payers. The FTC requires substantial integration for separate practices to form an entity that can negotiate on behalf of the group.
The FTC investigated but did not challenge two major mergers that substantially changed the landscape of the pharmacy benefit management and managed care industries.  

In an impressive show of legislative strength, those supporting the National Resident Matching Program (NRMP), after losing on several motions to dismiss in a district court in Washington, D.C., successfully persuaded Congress to pass an exemption from the antitrust laws for the NRMP in an unrelated piece of pension legislation.

**Fraud and Abuse, Self-Referrals, and False Claims**

The Practice Group leadership focused on developments in false claims case law, the release of the Stark II, Phase II regulations, and a relatively new area of focus—the costs of prescription drugs.

In 2001, the Ninth Circuit held that a district court’s treble damages award under the federal False Claims Act is subject to analysis under the Eighth Amendment’s excessive fines clause. On remand, the district court upheld the award under the Eighth Amendment, and last August, the Ninth Circuit upheld the district court’s decision. Mackby, a non-physician who controlled a physical therapy clinic, used his father’s personal identification number to file false claims with Medicare. The appeals court found that the fine in this instance was not grossly disproportionate to the gravity of the wrongdoing.

In an expansion of relator rights, the Sixth Circuit held that a relator is entitled to share in the proceeds of a governmentally negotiated settlement when the government decides to pursue a settlement rather than intervene in a relator’s qui tam suit. The appeals court held that the settlement between the government and defendants constituted an “alternate remedy” to intervention in the qui tam suit under the terms of the False Claims Act, thereby entitling the relator to a portion of the proceeds from the settlement.

Providers should be on notice that disciplinary action of an individual after the individual has given notice of a potential qui tam action will be scrutinized carefully for evidence of retaliation. A district court in Indiana refused to dismiss a physician’s retaliation claim against his employer when the employer was on notice that there was a distinct possibility of a qui tam action by the physician.

On March 26, 2004, CMS released the “Phase II” final rule under the Stark Law. Phase II contains new exceptions and improvements, but may also jeopardize some existing arrangements.

In Massachusetts, a federal district court rejected a motion to dismiss, finding that plaintiffs in a proposed class action against pharmaceutical manufacturers
and pharmacy benefit managers had sufficiently alleged a Racketeer Influenced and Corrupt Organizations (RICO) enterprise to fraudulently inflate average wholesale prices. This case demonstrates the increased interest and imagination of plaintiffs' counsel in pursuing cases related to pharmaceutical pricing.

**Healthcare Liability and Litigation**

The Practice Group leadership discussed important cases involving mandatory arbitration agreements and vicarious liability that will be of interest to long term care providers and hospitals.

Florida courts ruled both ways on the permissibility of mandatory arbitration agreements in resident admission contracts. In *Romano ex rel. Romano v. Manor Care*, a Florida appeals court found that an agreement to use mandatory arbitration, including limitations on non-economic damages and an exclusion of punitive damages, was substantively unconscionable. In contrast, another Florida appellate court found that a mandatory arbitration agreement in an admissions agreement was not unconscionable because the individual and family members had time to read it and a choice about signing it. Both cases indicate that institutions seeking to use mandatory arbitration agreements must be careful about the manner used to negotiate them with consumers.

The Georgia Supreme Court made an important ruling related to vicarious liability, holding that a hospital was not liable for the sexual misconduct of an employee. The supreme court reasoned that the employee’s sexual misconduct was not in furtherance of his employer’s business and fell outside the scope of his employment. A forceful dissent argued that the majority opinion effectively ruled that respondeat superior does not apply to cases of sexual misconduct.

A New Hampshire federal district court granted summary judgment to Concord Hospital when the hospital was sued for the alleged negligence of an anesthesiologist and a certified registered nurse anesthetist who were independent contractors. Because the hospital had not maintained any appearance from which a reasonable person could conclude the medical personnel had the apparent authority to provide services at its behest, the court rejected a vicarious liability theory.

**Health Information and Technology**

The HIT Practice Group focused less on cases and more on regulatory and policy developments.

Among the biggest developments of the year were the broad array of provisions touching on health information technology included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The leadership mentioned
the provision to extend the telemedicine demonstration project, the Commission on Systemic Interoperability, and matching grants for physicians to acquire electronic prescribing hardware and software, among others.

Privacy-related litigation played heavily in the battle over constitutional challenges to the Partial Birth Abortion Ban of 2003. Courts in California, Illinois, and New York handled motions to quash third-party subpoenas by the government to determine whether the abortion procedures banned by the Act were ever medically necessary.

A federal district court in Chicago held that Illinois’ more stringent privacy laws justified the quashing of a DOJ subpoena to Northwestern Memorial Hospital. The court reasoned that HIPAA’s pre-emption clause incorporated the more stringent Illinois privacy laws into federal law that governed the enforcement or quashing of the subpoena.

A New York federal court reached a different conclusion and enforced a similar subpoena against New York and Presbyterian Hospital. The court distinguished between incorporating more stringent state law and allowing more stringent state law to continue to operate in its sphere of influence.

In a demonstration of the growing importance of health information technology, President Bush signed an executive order on April 27, 2004, creating a National Health Information Technology Coordinator at the sub-cabinet level. The coordinator will direct a plan to move the nation towards an interoperable, secure, health information system that will reduce medical errors, improve quality, and produce efficiencies. The President then appointed David Brailer, M.D., Ph.D., to the post.

**HMOs and Health Plans**

The HMOs and Health Plans Practice Group focused its review on a number of significant ERISA pre-emption cases, the tension that still exists between providers and plans, and the passage of significant state and federal legislation.

Circuit courts struggled with the aftermath of *Pegram v. Herdrich* and the difference between a health plan’s coverage decision, governed by federal law, and a health plan’s treatment decision, which can be subject to state malpractice actions. In *Land v. CIGNA Healthcare*, the Eleventh Circuit held that an HMO-employed nurse’s decision to discharge a patient, against the advice of the patient’s physician, was a mixed eligibility and treatment decision and remanded the case back to state court to be tried as a malpractice case under state law.

The Third Circuit came to a different conclusion fifteen months ago when Aetna denied as medically unnecessary a specially designed tracheotomy prescribed by a patient’s physician. The appeals court found this type of claim to be
completely pre-empted by ERISA. As referenced in the Top Ten, the U.S. Supreme Court will be exploring the issue of ERISA pre-emption in Davila and Calad, consolidated and argued earlier this year.

The economic tensions between providers and plans continued to be an important development over the last twelve months. Plans won a victory in persuading the Eleventh Circuit to follow an earlier U.S. Supreme Court holding by requiring physicians to arbitrate their class action RICO claims. On the other hand, plans also settled with physicians for significant sums in certain class action suits. In addition, a Texas jury awarded $13 million in a suit brought under a 1997 Texas law allowing insureds to sue health plans for damages relating to benefit determinations.

The federal government and the State of California passed significant legislation relating to health plans, insurance, and health care coverage. Title II of the MMA established the Medicare Advantage Program designed to reinvigorate the offering of managed care to Medicare beneficiaries. The Medicare Advantage Program increases reimbursement for Medicare managed care plans immediately, authorizes a number of reforms, and, in 2010, initiates a six-year demonstration project to test competition between private plans and the original Medicare fee-for-service program.

California, in an effort to increase the insured population, enacted legislation mandating private, employer-funded health benefits. Traditionally known as “pay or play,” the reforms generally require an employer to provide coverage to employees by a certain date or pay into a state-administered fund. The legislation has caused quite a furor in the business community, with a coalition being formed to urge its repeal.

**Hospitals and Health Systems**

The Hospitals and Health Systems Practice Group analyzed significant cases on vicarious liability, reimbursement, and EMTALA.

As they do every year in medical malpractice actions, state courts wrestled with the vicarious liability doctrine and cases in which independent contractor physicians act with the apparent authority of the hospital. In Roessler v. Novak, a Florida appellate court refused to grant summary judgment to a hospital regarding the alleged negligence of an independent contractor radiologist because the court found a genuine issue of material fact about whether the radiologist was the hospital’s apparent agent. In contrast, a Kentucky appeals court weighed heavily the fact that a patient signed an authorization form clearly stating that the emergency room physician was an independent contractor in its decision to grant summary judgment to the hospital.
In a case of first impression and with a theme of turnaround is fair play, a Massachusetts federal district court held that the government must exhaust administrative remedies before filing a court action to recoup overpayments to a hospital. The government maintained that the relevant statutory section requiring exhaustion, 42 U.S.C. § 405(h), applied only to cases against the government. The University of Massachusetts Memorial Medical Center argued that the language of the statute fails to make that distinction. The court agreed with the latter argument.102

Hospitals obviously followed closely the final rule clarifying hospital obligations under EMTALA that was released last September.103 They also paid particular attention to revised EMTALA interpretive guidelines issued by CMS to its regional offices and state survey agencies on May 13, 2004.104

With respect to EMTALA case law, a Wisconsin appellate court held that a patient who came to a birthing center is not protected under EMTALA's stabilization requirement because the requirement applies only to patients who report to an emergency department. The court also followed the Eleventh Circuit's holding in *Harry v. Marchant*105 that EMTALA requires stabilization of a patient only when the patient is going to be transferred.106

**In-House Counsel**

The leaders of the In-House Counsel Practice Group cited cases involving disputes over professional rights, vicarious liability, medical malpractice, and organ donation. These cases often establish standards that will impact the day-to-day operations of healthcare providers.

The professional rights cases generally explore the conflict of rights inherent in hospitals taking quality-related actions against physicians. In *Meyers v. Columbia/HCA Healthcare Corp*, the Sixth Circuit held that the peer review protections afforded by the Health Care Quality Improvement Act (HCQIA) extend to all persons involved in the review process, including non-physicians.107 The California Supreme Court held that a state peer review protection statute establishes a qualified privilege rather than an absolute privilege, not protecting communications made with malice.108 A federal district court in Louisiana refused to recognize a federal privilege to protect medical peer review documents in a § 1983 action, finding no support for it in federal common law or in the HCQIA.109

Like the Hospitals and Health Systems Practice Group, the In-House Counsel Practice Group also explored several vicarious liability cases. The Practice Group leaders included cases demonstrating that courts will look behind agreements and objective factors to determine if a hospital actually exercises control over independent contractor physicians.110
The Texas Supreme Court issued two medical malpractice decisions of interest
to in house counsel. In *McIntyre v. Ramirez*, the Texas Supreme Court held that
a physician is not liable for damages under the state Good Samaritan law where
he had no duty to respond and was not expecting remuneration after responding.\(^{111}\) The supreme court also found that, under Texas law, parents do
not have the a cause of action for loss of consortium resulting from a non-fatal
injury to a child, even if a child can recover for the loss of consortium of a
parent.\(^{112}\)

In a case related to organ donation, in-house counsel will want to advise hospital
personnel to be careful and specific in explaining the details of organ donation. A
Missouri appeals court reversed a summary judgment in favor of a hospital and a
nurse in the face of a factual dispute over whether the nurse’s representations
made to the family of the decedent were accurate regarding the invasiveness of
organ harvesting.\(^{113}\)

**Labor and Employment**

The leadership of the Labor and Employment Practice Group summarized
significant labor and employment cases under numerous federal statutes,
including the Fair Labor Standards Act, the Age Discrimination in Employment
Act (ADEA), the Civil Rights Act of 1964, as amended in 1991 (CRA), and the
Family and Medical Leave Act (FMLA).

The D.C. Circuit held that a private, nonprofit hospital’s institution of new
management over a previously operated public hospital meant that the nonprofit
hospital was a successor employer under the National Labor Relations Act, and it
was required to bargain with the public hospital's existing union.\(^{114}\)

In a significant case for older workers, the U.S. Supreme Court held that General
Dynamics did not violate the ADEA when it promised to provide retiree health
benefits for employees over age fifty, but not for employees between forty and
fifty. Those in the latter category argued that they should fall within the statute’s
protected class, but are being denied benefits because of their age. The
Supreme Court argued that older workers are receiving favorable treatment,
which is not a violation of the ADEA.\(^{115}\)

The U.S. Supreme Court addressed both affirmative action under the
Constitution and the evidence needed to prove a mixed motive case under the
CRA. In two affirmative action cases involving the University of Michigan, the
Supreme Court distinguished between an acceptable affirmative action system
and one that violates the Constitution. The Court upheld the law school’s use of
race as a significant factor in an individualized approach to applications, finding
that it was narrowly tailored to further the school’s compelling interest in obtaining
the educational benefits that flow from a diverse student body.\(^{116}\) The Court
rejected the school’s undergraduate system of automatically granting minority applicants twenty points as not narrowly tailored to achieve diversity.\textsuperscript{117}

In a significant victory for plaintiffs in employment discrimination cases, the U.S. Supreme Court held that the CRA permitted plaintiffs to use circumstantial evidence to show that an employer had used a forbidden consideration in making an employment decision even though the business also had a legitimate business reason for the decision. This ruling will make it easier for plaintiffs to bring mixed motive cases under the CRA.\textsuperscript{118}

The Eleventh Circuit upheld a labor department regulation requiring that an employee be incapacitated for three full and consecutive days to have a serious health condition under the FMLA.\textsuperscript{119}

**Long Term Care**

The Long Term Care Practice Group focused on the use of mandatory arbitration clauses in resident contracts, a criminal conviction for a failure to report elder abuse, and two state laws, one impacting union organization in California and the other influencing the right to remove nutrition and hydration from a woman in Florida.

Tennessee courts provided guidance on how to draft enforceable arbitration clauses in resident contracts. In *Howell v. NHC Healthcare-Fort Sanders, Inc.*, a Tennessee appellate court found an arbitration clause in a residency contract unconscionable because the clause was “buried” on page ten of an eleven-page contract, did not clearly indicate the forfeiture of a jury trial, and was explained by an admissions coordinator to an individual who could not read or write.\textsuperscript{120}

In another Tennessee appellate decision, the court found that a husband’s signature on his mentally competent wife’s residency agreement could not bind the patient to arbitrate disputes with the nursing home.\textsuperscript{121}

In a case reinforcing the need to report cases of elder abuse, a Missouri court upheld a jury verdict against a nursing home, its management company, and the management company’s president for failure to report a case of serious elder abuse to a state hotline. The president was sentenced to one year in prison and a $1,000 fine, the maximum punishment for this misdemeanor.\textsuperscript{122}

The Ninth Circuit affirmed a district court’s ruling that the NLRA pre-empted a California statute making it unlawful for entities receiving in excess of $10,000 from the state to use any of those funds to advocate for or against unionization of their workplaces.\textsuperscript{123}

The Practice Group also focused on another state statute, Terri’s Law, that permitted Florida Governor Bush to reinstate a feeding tube after a court issued
an order permitting the tube’s removal. Terri Schiavo’s husband, Michael Schiavo, challenged the law’s constitutionality in a state lawsuit. A Pinellas County Circuit Court found the law unconstitutional, and the case is now on appeal.124

**Medical Staff, Credentialing, and Peer Review**

Practice Group leaders focused on many of the issues that have increased tensions between physicians and hospitals over the last twelve months, including exclusive contracting, economic credentialing, disruptive healthcare professionals, and due process rights under medical staff bylaws.

The Tennessee Supreme Court held that state law permits a public hospital to enter into an exclusive contract for its imaging department, refusing access to a radiology group that had opened a competing outpatient diagnostic imaging center.125

A trial court in Arkansas issued a preliminary injunction against a hospital’s enforcement of an economic conflict of interest policy that denied reappointment to the medical staff of any practitioner who directly or indirectly holds an ownership interest in a competing hospital.126

The Idaho Supreme Court upheld a hospital’s decision not to grant privileges to a physician with a long history of disruptive behavior. The hospital denied the physician’s application, finding that the disruptive behavior would interfere with hospital operations and patient care.127

The Wisconsin Supreme Court held that a suspended physician does not have a due process right to representation by an out-of-state attorney. The supreme court found that the words “legal counsel” as used in the medical staff bylaws refers to an attorney licensed in Wisconsin.128

**Physician Organizations**

The Physician Organizations Practice Group focused on the myriad issues that impact the practice of medicine in today’s complex, competitive healthcare environment, including recruitment and employment agreements, antitrust, discrimination, and malpractice issues.

A South Carolina appeals court enforced an arbitration provision in a recruitment contract between a cardiovascular practice and a physician, finding that the agreement was an “activity that involves interstate commerce.” The court reasoned that the agreement involved a monetary inducement to cross state lines.129 A Tennessee appellate court found a noncompete provision between a clinic and a physician enforceable because there is consideration in the
agreement, the clinic will suffer financially without the agreement, the employee’s economic hardship is minimal, and the agreement is in the public interest.\textsuperscript{130}

The Practice Group summarized two cases (and cited several more) in which the FTC issued complaints against physician practices for the methods used to negotiate rates with health plans.\textsuperscript{131} The FTC is concerned about price-fixing agreements between competitors adding to the cost of healthcare.

In a case of import to employers providing health benefits to their employees, the U.S. Supreme Court held that ERISA, unlike the Social Security Act, does not require special deference for a treating physician’s opinion when making a disability determination about an insured.\textsuperscript{132}

In an important labor decision for physicians, the Sixth Circuit held that independent contractor physicians cannot bring employment discrimination suits against the entities with whom they have contractual relationships.\textsuperscript{133}

Courts issued numerous malpractice decisions of interest to physician counsel. The Colorado Supreme Court allowed a medical malpractice action to go forward against the Kaiser Foundation Health Plan even though the decedent’s enrollment agreement contained a binding arbitration clause. The supreme court found that Kaiser had failed to meet the typeface and wording requirements of a Colorado law regulating arbitration agreements.\textsuperscript{134} In Florida, a hospital assumed a physician’s malpractice liability when the hospital failed to ensure that the physician had the insurance coverage required by law.\textsuperscript{135}

\textbf{Regulation, Accreditation, and Payment}

The last twelve months virtually exploded with payment enhancements for providers authorized by the MMA, new regulations emanating from that law, and accreditation developments from JCAHO as it strategized about ways to improve patient safety.

The MMA contains provisions to establish a transitional Medicare Prescription Drug Card Program, initiate a new Medicare Advantage Program, and enhance provider payments, among myriad other provisions. Several of these sections generated complex regulations produced by the DHHS rapidly after the passage of the new Act.

On December 15, 2003, only one week after the President signed the MMA into law, DHHS issued a notice of an intent to seek applications for the new Medicare Prescription Drug Discount Card.\textsuperscript{136} The Drug Discount Card program was then launched on May 3, 2004, with supporters and proponents debating whether it resulted in savings for seniors.\textsuperscript{137}
On January 16, 2004, CMS announced a significant increase in payment rates for Medicare Advantage health plans to take effect March 1. These increases were authorized by § 211 of the MMA, which was designed to increase plan participation by ensuring that participating plans are paid as much as fee-for-service plans. On May 10, CMS announced a 6.6% increase in payment rates for Medicare Advantage Plans in 2005.

On January 6, 2004, CMS published an interim final rule authorized by the MMA that increased payments to physicians by an average of more than 1.5% for calendar year 2004. This replaced a November 7, 2003, final rule that would have reduced physician payments.

In the area of accreditation, the Practice Group leaders focused on JCAHO announcements that enhanced its efforts to protect patient safety. JCAHO’s Board of Commissioners approved a universal protocol for preventing wrong site, wrong procedure, and wrong person surgery. All JCAHO-accredited organizations must follow this protocol effective July 1, 2004.

On January 1, 2004, JCAHO officially launched its new Shared Visions-New Pathways Accreditation Process. In December 2003, JCAHO announced that it had completed pilot testing at twenty-five pilot sites two components of the new process, the Periodic Performance Review and the Priority Focus.

The Practice Group leadership also reviewed a number of significant reimbursement cases by providers against the government, including Baystate Medical Center v. Thompson, in which a federal district court granted the plaintiffs’ motion for summary judgment and issued a writ of mandamus to the DHHS compelling the agency to reopen and revise certain determinations related to disproportionate share payments.

Tax and Finance

As referenced in the Top Ten, joint ventures topped the list of significant issues summarized by the Tax and Finance Practice Group.

St. David’s Health Care System has ridden a roller coaster of litigation after the IRS revoked its tax-exempt status following its entrance into a joint venture with a for-profit affiliate of HCA. In the last twelve months, the Fifth Circuit reversed an extremely favorable federal district court summary judgment decision in the nonprofit system’s favor. The Fifth Circuit held that material facts existed as to whether St. David’s retained control over the partnership, which could only be determined by examining the partnership’s actual operation.

The IRS also issued guidance on ancillary joint ventures, finding that a university may maintain its tax-exempt status when it contributes an insubstantial part of its
assets to an ancillary joint venture with a for-profit company that specializes in conducting interactive video training programs.  

In South Dakota, the attorney general sought to impose constructive trust law, rather than state nonprofit corporation law, to the sale of Banner Health System’s South Dakota assets. Banner Health System is an Arizona corporation that owns nursing homes and other assets in South Dakota. The attorney general sought to ensure that sales of the assets remained in the state. The South Dakota Supreme Court held that an implied charitable trust could apply to the sale of Banner’s South Dakota assets based on theories of unjust enrichment, breach of fiduciary duties, and improper amendment of the corporation’s articles of incorporation.

The IRS and state attorney generals were not the only arms of government scrutinizing the activities of nonprofit healthcare. Representative Bill Thomas of California, Chairman of the House Ways and Means Committee, stated that his committee would examine the tax-exempt status granted to nonprofit hospitals and other charitable entities. According to news reports, the scrutiny was prompted by a letter from the American Hospital Association to the Secretary of Health and Human Services questioning whether regulatory barriers prevented hospitals from offering discounts to the uninsured.

**Teaching Hospitals and Academic Medical Centers**

The Teaching Hospitals and Academic Medical Centers Practice Group summarized numerous cases in several important areas of law, including legal representation, Medicare and Medicaid payment issues, and indigent care issues.

Two courts awarded attorneys’ fees to those suing the Secretary of Health and Human Services for misapplication of Medicare law, finding that the government’s position was not substantially justified.

A California appeals court held internal incident reports privileged in a wrongful death suit because they were prepared for attorney review and designed to prevent accidents.

In a Medicare reimbursement case of importance to academic medical centers, a federal district court in Ohio found that resident hours do not need to be spent on direct patient care in order to be counted in the calculation of a teaching hospital’s indirect medical education cost adjustment under Medicare.

The Practice Group leadership summarized three cases that explored the legal requirement to exhaust administrative remedies in Medicare cases.
The Kansas Supreme Court applied the collateral source rule in a negligence action, refusing to limit the award for medical expenses to the amount actually paid by Medicare in a suit against Via Christi Health System. In a case of enormous interest to hospitals that use consultants to help maximize reimbursement, a Louisiana appeals court held that a hospital could recover from KPMG under a breach of contract theory when KPMG failed to maximize the hospital’s disproportionate share reimbursement.

Conclusion

Over the past twelve months, the federal government made a huge investment in healthcare. The MMA offers a prescription drug benefit for seniors, constructs a new Medicare managed care program, and increases reimbursement to all types of healthcare providers.

Providers were generally fortunate in their treatment by government, but testy in their relationships with each other. Not only did healthcare providers (and plans) receive increased reimbursement from Medicare, but DHHS also issued EMTALA regulations sensitive to their needs and at least attempted to honor the providers’ comments in issuing the final set of regulations on Stark II.

In spite of this good news, hospitals and physicians saw increased animosity in their relationships, including battles over specialty hospitals and the use of such tools as economic credentialing, exclusive contracting, loyalty oaths, and the strengthening of conflict of interest policies. The Practice Groups summarized numerous disputes between physicians and hospitals regarding the revocation of privileges.

The animosity between health plans and providers did not abate either. Plans continued to feel the heat from both providers and consumers. Plans settled several class action suits by providers and continued to battle in others. Plans lost a $13 million judgment in Texas and are awaiting decisions in two significant U.S. Supreme Court actions related to consumer lawsuits. Providers also felt pressure from consumer groups that challenged the undiscounted charges being billed to uninsured patients.

Over the last twelve months, the federal government, states, and consumers have struggled with the high cost of prescription drugs. The federal government passed legislation to subsidize the costs for senior citizens beginning in 2006 and to create a drug discount card in the interim. States and localities wanted to import drugs from foreign countries, where drugs are often priced less expensively than in the United States, but were opposed by the FDA.

While the economic pie for healthcare expanded remarkably in 2003 and 2004, the players in the healthcare arena still jockeyed for position to reap the benefits. The complexity of healthcare derives from the intertwined yet distinct roles of so
many different entities that work to keep our populace healthy. Hospitals, health plans, and healthcare professionals compete, yet are interdependent, and many rely significantly on federal and state governments for their livelihood. This intricate economic model leads to fascinating developments every year as the mission of healthcare meets the economic necessities of so many different actors.

This effort to boil one year’s worth of developments into a digestible whole may serve as a resource for you until Health Lawyers meets again in San Diego in 2005. Practice Group members expended great effort to make this resource available, and they should be commended for their achievement.159

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3 Id. at 15.
5 Id.
7 Id. at 16.
8 Id.
9 See supra n. 1 at Titles 4–10.
11 Id. at 53223.
12 Id. at 53224.
14 Id.
15 Id. at 3-4.
16 Id. at 4-6.
17 Id. at 6-10, 11.
18 Id. at 11.
19 Id. at 12.
20 See AGs Urge Adoption of Rx Import Procedure; CVS Chief Breaks Ranks to Endorse Imports, 9 BNA HEALTH CARE DAILY REPORT 87 (May 6, 2004) (Nineteen state attorney generals urge Secretary Thompson to adopt a procedure for importation of drugs).
28 The exceptions include the provision of information technology (with exceptions), a conditional temporary lapse in Stark compliance, retention payments in medically underserved areas, two Anti-Kickback safe harbors, and professional courtesy. See id. at 5.
29 Id. at 4-5.
32 Despite Setbacks, FTC Steps Up Activity In Health Care Enforcement, Official Says, BNA HEALTH CARE DAILY REPORT NO. 217 (Nov. 8, 2002).
35 Eisenberg, Specialty Hospitals: The Great Divide, 6 HOSPITALS AND HEALTH SYSTEMS Rx 1, 5 (Spring 2004).
38 Id.
40 530 U.S. 211 (2000).
42 See Estrada and Jay, Current Issues in Managed Care Litigation and ERISA Pre-Emption, American Health Lawyers Ass’n and America’s Health Insurance Plans Law Conference for Health Plans, Providers, and Insurers 7-9 (May 2004).
44 See Estrada and Jay, supra, n. 42 at 8-9, citing Brief for Petitioner Aetna Health Care, Inc., No. 02-1845, at 6-9 (U.S. filed Dec. 18, 2003).
45 Brief for Respondents Juan Davila and Ruby Calad, Nos. 02-185 and 03-83 at 1-4.
50 Id.
53 Id. at 26.
54 Letter from Richard J. Davidson to the Honorable Tommy G. Thompson (Dec. 16, 2003).
55 Bowden and Foust, supra at 26, n. 52.
57 Bowden and Foust, supra at 27, n. 52, at 27.
58 St. David’s Health Care System, Inc. v. United States, 349 F.3d 232 (5th Cir. 2003).
60 Id. at 3–15.
61 Hilvert, St. David’s Tax Exemption Upheld Again, 2 HEALTH LAWYERS WEEKLY 10 (Mar. 12, 2004).
63 See http://www.ftc.gov/ogc/healthcare hearings.
70 United States v. Mackby, 261 F.3d 821 (9th Cir. 2001).
71 United States v. Mackby, 339 F.3d 1013 (9th Cir. 2003).
72 Id. at 1017.
74 Id. at 647.
76 See notes and accompanying text, supra n. 26-29.
83 Id. at § 417.
84 Id. at § 1012.
85 Id. at § 108.
86 See supra n. 46 and accompanying text.
88 Id.
90 Id.
91 Bush Sets 10 Year Goal of Medical Records Going Electronic; Announces Health IT Post, 9 BNA HEALTH CARE DAILY REPORT 80 (Apr. 27, 2004).
92 Land v. CIGNA Healthcare, 339 F.3d 680 (11th Cir. 2003).
94 See supra n. 40-45 and accompanying text.
95 In re Humana Inc. Managed Care Litigation, 333 F.3d 1247 (11th Cir. 2003).
96 See www.cignaphysiciansettlement.com (CIGNA to create settlement fund of $30 million).
99 Coalition Gathers 620,000 Signatures in Effort to Repeal Health Insurance Mandate, 89 BNA HEALTH CARE DAILY REPORT 231 (Dec. 2, 2003).
103 See supra n. 10 – 19 and accompanying text.
104 CMS Issues Revised EMTALA Interpretive Guidelines, 2 HEALTH LAWYERS WEEKLY 21 (May 21, 2004).
105 291 F.3d 767 (11th Cir. 2002).
107 341 F.3d 461 (6th Cir. 2003).
112 Roberts v. Williamson, 111 S.W.3d 113 (Tex 2003).
114 Community Hosps. v. NLRB, 335 F.3d 1079 (D.C. Cir. 2003).
122 Chamber of Commerce v. Lockyer, 364 F.3d 1154 (9th Cir. 2004).
124 City of Cookeville v. Humphrey, 126 S.W.3d 897 (Tenn. 2004).
127 Seltzinger v. Community Health Network, 676 N.W.2d 426 (Wis. 2004).
137 See CMS Announces 10.6% Average Increase in Payment Rates for Medicare Managed Care Plans,2 HEALTH LAWYERS WEEKLY 4 (Jan. 23, 2004).
140 CMS Announces 6.6% Increase in 2005 Medicare Advantage Payment Rates, 2 HEALTH LAWYERS WEEKLY 20 (May 14, 2004).
142 Id.
145 Id.
147 St. David’s Health Care Sys., Inc. v. United States, 349 F.3d 232 (5th Cir. 2003).
150 Id. at 248.
151 See supra n. 54-57 and accompanying text.
155 See Kaiser v. Blue Cross, 347 F.3d 1107 (9th Cir. 2003) (constitutional and statutory claims inextricably intertwined with Medicare benefit determinations require exhaustion of administrative remedies); Fanning v. United States, 346 F.3d 386 (3d Cir. 2003) (recovery of Medicare payments from settlement of product liability claim arose under Medicare Act and required exhaustion); Bartlett Mem’l Med. Ctr., Inc. v. Thompson, 347 F.3d 828 (10th Cir. 2003) (challenge of validity of Secretary’s action does not require exhaustion of remedies).
158 See Cooper, Gosfield, Heagen, Peters and Raspani, Why Can’t We All Just Get Along, American Health Lawyers Ass’n Hospitals and Health Systems Law Institute (Feb. 12, 2004).
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FTC Objects to Rhode Island Bills Resulting in Any Willing Provider Laws
In an April 8, 2004, letter to the Rhode Island attorney general and state senate leader, the Federal Trade Commission (FTC) expressed its opposition to seven Rhode Island “freedom of choice” bills. Each bill would limit the ability of health plans to restrict consumers’ freedom of choice in selecting where to obtain pharmaceutical services. In effect, the bills would prevent selective contracting by payers. The FTC noted that restricted panels of providers can lower consumer healthcare costs by increasing the volume of chosen providers, lowering their costs, and thus inducing them to grant payers lower prices.


Antitrust Division Announces Closure of Anthem/WellPoint Investigation
On March 9, 2004, the Antitrust Division announced that it had completed its investigation of the Anthem, Inc.-WellPoint Health Network, Inc., merger, and had decided to take no action to block the transaction. The Division noted that both parties were Blue Cross licensees but that their Blue Cross plans operated in different areas and did not compete. The other plans of the parties did compete to some extent in nine states, but, according to the Division, WellPoint’s market share in each state was too small to raise competitive concern. The Division also explained that it examined the possible monopsony ramifications of the transaction but, again, found that WellPoint’s market share as a purchaser of healthcare services was too small to warrant antitrust concern.

Department of Justice Antitrust Division Statement on the Closing of Its Investigation of Anthem, Inc.’s Acquisition of WellPoint Health Networks, Inc. (U.S. Dep’t of Justice Antitrust Division Press Release Mar. 9, 2004).

U.S. Court in Pennsylvania Refuses to Dismiss Price-Fixing Claim Against PBMs
Plaintiff pharmacies brought a class-action antitrust suit under § 1 of the Sherman Act, alleging that the defendant pharmacy benefit management (“PBM” company engaged in a per se unlawful price-fixing agreement by negotiating pharmacy prescription drug and dispensing prices and fees with individual pharmacies on behalf of the numerous health plans for which defendant provided PBM services. According to plaintiffs, but for the PBM’s joint negotiations on behalf of the plans, the plans would have to compete to purchase from the pharmacies.

The U.S. District Court for the Eastern District of Pennsylvania rejected defendant's motion to dismiss for failure to state a claim, noting that price-fixing agreements among buyers, just as price-fixing agreements among sellers, constitute unreasonable restraints on competition violative of § 1. Plaintiffs alleged that each of the health plans was aware of defendant’s activities and that this fact could provide an inference
that defendant acted with their understanding and acquiescence and thus that each party could be a co-conspirator in the price-fixing scheme. Plaintiffs pled that all the parties acted in a parallel manner, that each party was conscious of the other’s conduct, and that each party had a motivation to enter into the alleged conspiracy. These allegations, according to the court, were sufficient to state a claim for unlawful buyer horizontal price-fixing in violation of § 1.


*This case demonstrates the possibility of legal consequences for parties engaged in price-fixing agreements among buyers.*

**Radiologist Loses Staff-Privilege/Exclusive Contract Antitrust Suit**

Plaintiff radiologist was a member of the single radiology group that had an exclusive contract with defendant hospital. Because of internal disputes, the group formed a new medical practice that did not include plaintiff and obtained the exclusive contract with the hospital. Because plaintiff was not a member of the group with the exclusive contract, he lost his privileges at the hospital. He found a position with a nearby health system, but brought suit under §§ 1 and 2 of the Sherman Act, challenging the exclusive contract.

The U.S. District Court for the District of New Jersey granted defendants’ motion for summary judgment after discovery. First, the court held that plaintiff failed to show antitrust injury because only he, and not competition, was injured by the alleged violation. The court explained that two relevant markets were potentially affected—that in which consumers purchase radiology services, and that in which radiologists compete for jobs providing radiology services. As to the first, the alleged restraint had no effect on consumers because consumers did not select their radiologist and were generally unaware of who read their tests. As to the second market, the court held that the market was geographically broad in scope because radiologists competed for jobs over a large geographic area. It pointed to the fact that plaintiff was easily able to locate a nearby job. Accordingly, there was no adverse effect in that market either.


*The court found no antitrust injuries because consumers were not affected by the alleged antitrust, and because the market was geographically broad in scope.*

**FTC Brings First Hospital Merger Case Resulting from Hospital Merger Retrospective**

On February 10, 2004, the FTC challenged the acquisition by Evanston Northwestern Healthcare Corp. (ENH) of Highland Park Hospital in 2000. Both facilities are in the north-Chicago suburbs. This is the first hospital-merger challenge resulting from the FTC’s hospital-merger retrospective, launched in August 2002, in which the FTC examined a number of consummated hospital mergers to determine their anticompetitive and efficiency effects. According to the FTC’s complaint, Northwestern’s acquisition of Highland Park increased the Herfindahl-Hirschman
Index (HHI) by some 500 points to over 3,000. (According to the federal government’s *Horizontal Merger Guidelines*, a market is “highly concentrated” if the HHI is above 1,800. In addition, the FTC alleged that the merger had actually resulted in significantly higher prices, including a 60% price increase in the case of one payer.

During the course of the investigation, the FTC also discovered that a physician network affiliated with ENH was jointly negotiating fee-for-service contracts on behalf of its physicians, and one count in the complaint challenges that conduct as an unlawful price-fixing agreement. ENH refused to sign a consent order with the FTC with respect to the merger challenge, and the matter is presently in adjudication before an FTC administrative law judge.

**Evanston Northwestern Healthcare Corp. and ENH Medical Group, Inc., Dkt. No. 9315 (Fed. Trade Comm’n filed Feb. 10, 2004).**

**U.S. Court in Massachusetts Refuses to Dismiss Average Wholesale Price Pharmaceutical Antitrust Suit**

Plaintiff consumers alleged that some forty-two pharmaceutical firms conspired to artificially raise the average wholesale price of certain pharmaceuticals to benefit physicians. The “spread” between the actual cost of the drugs and the average wholesale price, profits to physicians, induced them, according to the complaint, to use the drugs, increasing Medicare Part B co-payments. The court denied defendant’s motion to dismiss for failure to state a claim, noting that plaintiffs had sufficiently alleged a price-fixing conspiracy, which would be per se unlawful if proven.

**In re Pharmaceutical Industry Average Wholesale Price Litigation, 2004-1 Trade Cas. (CCH) ¶ 74,305 (D. Mass. 2004).**

*This case demonstrates a court’s willingness to consider a conspiracy claim related to the alleged artificial raising of the average wholesale price of certain pharmaceuticals.*

**FTC Closes Investigation of Caremark/AdvancePCS Merger Without Challenge**

On February 9, 2004, the FTC announced that it had closed its investigation of the acquisition of AdvancePCS by Caremark Rx. Both firms are large, national PBM firms. The FTC concluded there are a sufficient number of national and regional PBM firms that health plans and employers could circumvent any attempted price increase by Caremark/Advance by purchasing PBM services from other firms. The FTC also investigated the potential monopsony power ramifications of the transaction, concluding that, although the transaction might result in lower prices paid by PBMs and health plans to pharmacies for pharmaceuticals and dispensing services, these lower prices would result from increased efficiencies rather than monopsony power, thus benefiting consumers.

**Statement of the FTC in the Matter of Caremark Rx/AdvancePCS (Fed. Trade Comm’n Feb. 9, 2004)**

**Brown & Toland Medical Group Settles Price-Fixing Charges with FTC**

On February 9, 2004, the FTC announced that its price-fixing charges against the Brown & Toland medical network had been withdrawn from adjudication and that the
parties had reached an agreement on a consent order. Brown & Toland is a large physician network located in San Francisco that had contracted with payers on a risk basis for many years. In recent years, Brown & Toland had introduced a preferred provider organization (PPO) network that contracted with payers on a fee-for-service basis. In July 2003, the FTC filed a complaint against Brown & Toland after a long investigation, alleging that the network violated § 5 of the FTC Act by negotiating the price terms of fee-for-service contracts with payers. Brown & Toland refused to sign a consent order at that time, and the matter went to adjudication before an FTC administrative law judge. The consent order will end the litigation. The consent order agreed to by the parties enjoins Brown & Toland from negotiating fee-for-service contracts unless it either shares risk or clinically integrates. California Med. Group, Inc., Dkt. No. 9306 (Fed. Trade Comm’n Feb. 9, 2004).

U.S. Court in District of Columbia Dismisses Some Defendants, Not Others, in Resident Match Antitrust Litigation
Three former residents, in a plaintiffs’ and defendants’ class action, sued some twenty-nine graduate medical education residency programs and seven medical and hospital organizations, alleging a massive antitrust price-fixing conspiracy to fix, stabilize, and depress the level of stipends paid to medical residents. The complaint alleged that the conspiracy consisted of three overt acts: the match program itself, certain accreditation standards of the Accreditation Council on Graduate Medical Education, and stipend-information exchange programs operated by the American Medical Association and Council of Teaching Hospital. Several defendants moved to dismiss for lack of personal jurisdiction and failure to state a claim. In addition, defendant National Residents Matching Program (NRMP) filed a motion to dismiss based on arbitration provisions in contracts between it and residents using the match program.

With one exception, the court denied defendants’ motions to dismiss for lack of personal jurisdiction, finding that part of the alleged conspiracy occurred in the jurisdiction in which the case was filed. The court did grant several of the organizations’ motions to dismiss for failure to state a claim because the complaint contained insufficient facts to support their participation in the alleged conspiracy. The court denied NRMP’s motion to dismiss and order arbitration because only the match was subject to arbitration, and sending that matter to arbitration would fragment the plaintiffs’ conspiracy case. Jung v. American Ass’n of Med. Colleges, 300 F. Supp. 2d 119 (D.D.C. 2004).

The court allowed various claims to proceed after finding that part of the alleged conspiracy occurred in the jurisdiction in which the case was filed.

Congress Passes, and President Signs, Exemption Legislation for Match Program
Shortly after the court in the Residents Match Antitrust Litigation denied most of the motions to dismiss, Congress enacted legislation providing that the NRMP yearly match process does not violate the antitrust laws. In addition, the legislation provides
that evidence of the match program may not be used as evidence in antitrust cases. The legislation, however, provides that nothing in its provisions provides an antitrust exemption for agreements fixing the price of resident stipends.

**U.S. Court in Missouri Applies HCQIA to Staff Privilege Antitrust Suit**

Defendant hospital, after a peer review proceeding, revoked plaintiff HIV specialist’s privileges because of her questionable drug prescribing and disruptive behavior. An outside expert reviewed and found problems with her cases. A peer review committee voted to suspend her privileges, and the medical executive committee concurred. Plaintiff demanded and received a hearing. The hearing committee recommended that plaintiff’s privileges be restored with conditions or otherwise be revoked. The executive committee met again, but voted to revoke plaintiff’s privileges. An appellate committee and the hospital board affirmed. Plaintiff sued under § 1 of the Sherman Act.

In holding that Health Care Quality Improvement Act (HCQIA) applied, the U.S. District Court for the District of Missouri cited the act’s rebuttable presumption that a professional review action met the statutory requirements. The court noted that it was irrelevant whether the outside expert’s medical judgment was medically sound, because HCQIA’s objective inquiry focuses on whether the action was taken with reasonable belief that it would further quality healthcare. The court explained that even the peer reviewers’ subjective bias or bad faith was irrelevant to the objective inquiry. Plaintiff’s evidence from other specialists would not overcome this burden. In discussing the hospital’s peer review procedure, the court noted that it examines the totality of the circumstances and that revocation of plaintiff’s privileges did not occur until after requisite notice and hearing procedures. It did not matter, according to the court, whether the professional review action reached a correct result. Rather, plaintiff did not meet her burden of proving that the reviewers lacked a reasonable belief that they were furthering quality healthcare in taking the action they did. Because the court held that the act applied, it did not need to reach the merits of plaintiff’s antitrust claims.


*This case emphasizes that the HCQIA’s rebuttable presumption in favor of professional review actions can be applied in an antitrust suit filed by a physician.*

**Hospital Settles PHO Price-Fixing Suit with FTC**

A hospital in Hickory, North Carolina, entered into a consent order with the FTC, prohibiting it from facilitating a price-fixing agreement among physicians on its staff who were members of a physician hospital organization (PHO) that the hospital had helped establish and operate. The PHO, according to the FTC, then negotiated the prices in non-risk contracts with payers, and hospital officials allegedly participated in the negotiations.

The order enjoins the hospital from participating in, or facilitating, the negotiation of non-risk contracts with payers.

Texas Network Agrees Not to Fix Prices in Negotiating Contracts with Payers
The FTC settled a price-fixing case against Memorial Hermann Health Network Providers. The case had alleged that the network, using a defective messenger arrangement, negotiated fee-for-service contracts with third-party payers on behalf of its physician members. The order is the usual order in network joint-negotiations cases, enjoining the network from negotiating contracts with payers unless it becomes a risk-bearing or clinically integrated group.

FTC Sues Hickory, North Carolina PHO, Which Refused to Settle
On December 24, 2003, the FTC filed a price-fixing suit against Piedmont Health Alliance and ten of its physician members, alleging that the respondents engaged in unlawful price-fixing of physician prices in violation of § 5 of the FTC Act. According to the FTC’s complaint, the PHO adopted a “modified messenger arrangement” in 2001, but unlawfully continued to negotiate aggregate payment levels with payers. The PHO decided to litigate the matter, which is in FTC adjudication at the present time.

FTC Wins Major Case Involving Agreement Delaying Market Entry by Generic Drug Makers
The full FTC held that 1997 and 1998 agreements settling patent infringement litigation between Schering-Plough Corp., a branded drug manufacturer, and two generic drug manufacturers constituted an unlawful market-allocation agreement that delayed the generic manufacturers from entering the market and competing against Schering’s branded drug K-Dur 20, which treats patients with low potassium. The FTC found that, after Schering sued the generic companies for patent infringement, it entered into agreements with them by which Schering paid them to defer the introduction of their generic products. An FTC administrative law judge had found for Schering. The full Commission reversed after applying a quick-look rule-of-reason standard.

U.S. Court in District of Columbia Upholds Standing of Payers to Sue for Antitrust Violation Increasing Price of Prescription Drug
Third-party payers filed a class action antitrust suit against a pharmaceutical manufacturer for overcharges resulting from the manufacturer’s antitrust violation in entering into an exclusive contract with the only supplier of an ingredient necessary for the drug’s production. According to the complaint, the exclusive contract foreclosed other manufacturers from making the drug, which permitted the manufacturer to charge supracompetitive prices for the drug.
The U.S. District Court for the District of Columbia held that, even though plaintiffs were insurers rather than the consumer of the drugs, they had standing to sue for the overcharges because they were the real purchaser and had actually paid for the drugs. 


This case demonstrates that insurers have the necessary antitrust standing to sue drug makers for overcharges because they were the real purchasers of the drugs.

**FTC Enters Consent Order with “Sham” Medical Group for Price-Fixing**

On Nov. 14, 2003, the FTC entered into a consent order with Surgical Specialists of Yakima (SSY), a limited liability corporation (LLC) that had been organized by several independent medical practices to negotiate contracts with third-party payers. According to the FTC’s complaint, the independent practices, which competed with one another, formed SSY in an effort to obtain “single entity treatment” under the antitrust laws when they negotiated contracts as a group. In practical effect, however, the practices remained separate because they integrated relatively few functions into the LLC. Also according to the complaint, SSY was able to negotiate significantly higher reimbursement than the groups had been able to negotiate individually.


**Sixth Circuit Dismisses Physician’s Antitrust Claim to Interpret Cardiology Tests at Hospital**

The Sixth Circuit affirmed the district court’s decision granting defendant’s motion to dismiss for failure to state a claim where defendant hospital had determined not to permit plaintiff internist to interpret non-invasive cardiology tests for the hospital. Plaintiff had been a member of a physician panel at the hospital that had interpreted EKG and Holter tests. After the hospital formed a partnership with another hospital, the hospitals decided to institute a new policy providing that membership on the interpretation panel would be based on a formula awarding points to physicians based on their performance of such tasks as providing consults, serving as medical-staff officers or on hospital committees, supporting the hospital’s residency program, and teaching continuing medical education (CME) courses. Based on the policy, plaintiff was not selected for the panel, and he filed an antitrust suit.

The appeals court, however, held that plaintiff failed to allege the requisite anticompetitive effects on market-wide competition. He admitted that ten other hospitals in the area provided the services in question and he failed to allege that the new policy resulted in higher prices or the inability of physicians to provide the
services in question elsewhere. For the same reason, the court rejected a claim of monopolization against the hospital.  

*This case is significant because it emphasizes a plaintiff physician’s need to allege that a hospital’s staff decision affected market-wide competition.*

**FTC Staff Advisory Opinion Approves Physician Fee Survey**  
On Nov. 3, 2003, the FTC issued a staff advisory opinion to the Medical Group Management Association (MGMA), stating no intention to challenge a program by which MGMA would collect and disseminate charge and reimbursement information. MGMA would conduct a survey of physician practices, including the amounts that health plans paid for physician services. MGMA would then aggregate that information and disseminate it to members who would then use the information in making informed decisions about whether to accept certain offers from payers.

The FTC staff noted that the program would not meet the requirements for antitrust-safety zone treatment under Statement 6 of the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, and that there was some chance that medical practices might use the information to fix prices or agree not to deal with certain payers. But the staff explained that these problems were not inherently likely to occur and that, on balance, the program likely would promote competition.  

**U.S. Court in Pennsylvania Upholds Ability of Hospital Alliance to Negotiate Contracts**  
In 1994, two health systems in Lycoming County, Pennsylvania, formed the Susquehanna Health System after entering into a consent decree with the Pennsylvania attorney general permitting the transaction to proceed under the condition that the system achieve a designated level of efficiencies and agreed to other constraints on its competitive behavior. All business was conducted under the system umbrella, and the hospitals consolidated almost all services. In 1996, the system merged the employed physician groups of both previously independent systems. In 2001, a health plan that contracted with the system filed suit under § 1 of the Sherman Act alleging, among other things, that the system’s negotiating contracts for both its hospitals and physicians constituted per se unlawful price-fixing agreements in violation of § 1 of the Sherman Act because the hospitals were not a single entity under the *Copperweld* doctrine.

The U.S. District Court for the Middle District of Pennsylvania rejected these claims, finding that the hospitals had totally integrated almost all their operations and thus that the system operated as a single entity for purposes of § 1. The court noted all the ways the system had integrated, even though the hospitals had not merged in a technical sense. It concluded that, “[a]lthough the organizational form employed here is unique, the court finds that the Alliance functions as a single entity. Defendants’
composition is akin to a corporate parent (Susquehanna Alliance) and its subsidiaries (the hospitals and Affiliates) . . . . [T]he defendant hospitals are helpless to act without the approval of Susquehanna Alliance. Decisions, therefore, are not the product of conspiracy.”


This case shows that consolidated hospitals that have totally integrated most of their operations operate as a single entity for purposes of § 1 of the Sherman Act.

FTC, Super PHO in Georgia Enter into Consent Agreement Preventing Hospital and Physician Price-Fixing

On October 31, 2003, the FTC entered into a consent order with South Georgia Health Partners, LLC, by which the “super” PHO agreed to cease and desist from alleged price-fixing activities. South Georgia consisted of five individual PHOs and three individual independent physician associations (IPAs). In all, it included over 2,200 hospital beds and 500 physicians covering an area of south Georgia. According to the complaint, the super PHO negotiated contracts with payers on behalf of all its hospitals and physicians, and the prices it obtained were significantly higher than those in other areas of Georgia. The consent order negotiated by the parties enjoined the super PHO’s price-fixing activities, although it permitted the respondent to form a “qualified risk-sharing” or “qualified clinically integrated” joint venture.


Oregon Jury Awards Hospital $16 Million in Suit Against Larger Competitor

On October 31, 2003, a Eugene, Oregon jury awarded McKenzie-Willamette Hospital in Springfield about $16 million in trebled damages against its larger competitor, PeaceHealth, for entering into an unlawful exclusive agreement with Blue Cross and attempting to monopolize the market for hospital services in and around Eugene. The jury rejected monopolization and conspiracy-to-monopolize claims against defendant. According to the complaint, defendant provided about 73% of hospital services in the relevant market. Also according to the complaint, defendant entered into an exclusive contract with Blue Cross resulting in plaintiff’s substantial foreclosure from the market, acquired other hospitals and physician practices, and announced plans to construct a new hospital close to plaintiff’s hospital. Defendant has appealed the decision.


The $16 million treble damages verdict is a cautionary award for insurers who might attempt to monopolize a market for hospital services.

U.S. Court in Texas Grants Hospital Summary Judgment in Staff Privilege Antitrust Suit

The U.S. District Court for the Northern District of Texas, in a staff-privilege antitrust suit, rejected plaintiff physician’s claim that suspension of his catheter lab privileges
violated § 1 or 2 of the Sherman Act. After several incident reports were filed concerning plaintiff’s work and behavior, his privileges were summarily suspended. This resulted in a medical staff review of his work and appointment of an ad hoc committee that reviewed some forty-four of plaintiff’s cases. The committee determined that twenty-nine of the cases indicated substandard care. The ad hoc committee reported this finding to an internal medicine advisory committee, which included one of plaintiff’s competitors and which recommended that plaintiff’s privileges be suspended. The matter continued through the normal medical staff peer review procedure, and the board ultimately upheld the recommendation to suspend plaintiff’s privileges.

According to the court, plaintiff was unable to prove the requisite conspiracy. As the court explained, “monitoring the competence of physicians through peer review is clearly in the public interest, and revocation or suspension of a physician’s privileges because of legitimate concerns about the quality of patient care that he rendered is obviously a lawful objective.” Moreover, plaintiff was unable to show that the hospital’s action had any effect on competition because plaintiff continued to have active privileges at five other hospitals and courtesy privileges at two more. Finally, with respect to plaintiff’s § 1 and § 2 claims, the court held that he failed to define the relevant market.


This case demonstrates that physicians seeking to prove an antitrust conspiracy arising out of a staff-privilege decision must demonstrate that such action affected competition.

FTC Staff Advisory Opinion Provides “Yellow Light” to Messenger Model Network

In a September 23, 2003, staff advisory opinion to Bay Area Preferred Physicians (BAPP), the FTC staff explained that it did not intend to challenge the network’s messenger arrangement, but warned that certain aspects of the program could raise antitrust problems depending on the facts. The staff expressed some concern about BAPP’s “50% rule,” by which the network would not contract with a network if less than 50% of the network’s members accepted a payer’s offer. According to the staff, the fact that the network refused to contract with the payer could “signal” physicians that the contract was unacceptable, and then physicians might refuse to contract with the payer on an individual basis. The staff concluded that, if the rule ultimately resulted in an agreement or understanding among physicians not to contract with a payer, the FTC might take action.

FTC, DOJ Conclude Healthcare Antitrust Hearings, Plan Report for Summer 2004

On October 1, 2003, the FTC and the Department of Justice concluded eight months of hearings studying a plethora of subjects related to healthcare competition law and policy. The hearings examined perspectives on competition policy and the healthcare marketplace, defining hospital product markets, defining hospital geographic markets, single-specialty hospitals, contracting practices, issues in litigating hospital mergers, horizontal and vertical hospital arrangements, the relevance of hospital nonprofit status, hospital joint ventures and joint operating agreements, post-merger hospital conduct, health insurance market definition issues, health insurance monopoly competitive effects, entry and efficiency considerations in health insurance monopoly issues, market definition in health insurance monopsony issues, competitive effects from health insurance monopsonies, countervailing market power in provider-payer relationships, most-favored-nations requirements, PHOs, quality and consumer information, Noerr-Pennington and state action exemption issues, information and advertising, mandated benefits, pharmacy benefit management issues, advisory opinions, delineation of physician product and geographic markets, physician information sharing, IPAs, network messenger arrangements, physician unionization, group purchasing organizations, Medicare and Medicaid, and civil and criminal antitrust remedies.

The agencies intend to issue a report based on the hearings, now scheduled for summer 2004.

FTC and Texas Network in Litigation Over Group’s Alleged Price-Fixing

On September 16, 2003, the FTC filed an enforcement action against North Texas Specialty Physicians, a physician contracting network in the Dallas-Ft. Worth Area. According to the complaint, the network has about 600 physician members and contracts with payers on both a risk and non-risk basis. The complaint alleged that the network obtains from its members the minimum prices they will accept, calculates the averages, reports these to its members, and obtains the physicians’ assurances that they will participate in networks at these prices. The network then will not consider price offers below these in dealing with payers. In effect, these amounts become the network’s minimum acceptable fees. According to the FTC, the networks developing and using this information, and negotiating, in dealing with payers results is horizontal price-fixing.

North Texas refused to enter into a consent order proposed by the FTC, and the matter is presently in adjudication before an FTC administrative law judge.


Antitrust Division Orders Physician Network to Dissolve

On September 15, 2003, a district court entered a consent decree on motion by the Antitrust Division requiring Mountain Health Care (MHC), an Asheville, North Carolina, physician-controlled PPO, to dissolve as a result of a complaint alleging that through
MHC, its physician members were fixing prices in violation of § 1 of the Sherman Act. According to the Antitrust Division’s complaint, MHC, which included some 90% of physicians in western North Carolina, had discouraged its members from contracting through other physician networks, and had been negotiating contracts using a network-developed fee schedule.

**United States v. Mountain Health Care,** 2003-2 Trade Cas. (CCH) ¶ 74,162 (M.D.N.C. 2003) (consent decree and competitive impact statement).

*This case cautions physician networks against discouraging their members from contracting through other networks.*

**Consultant and Baton Rouge Orthopedic Surgeons Settle Price-Fixing Charges with FTC**

On August 27, 2003, the FTC announced that it had settled price-fixing allegations against Physician Provider Network Consulting, L.L.C., its principal, and Professional Orthopedic Services, a Baton Rouge IPA of orthopedic surgeons. According to the complaint, the consultant, under the guise of a purported messenger arrangement, negotiated prices on behalf of the IPA, which consisted of twenty-eight orthopedic surgeons providing some 70% of the orthopedic surgery services in the Baton Rouge area.


**Eleventh Circuit Holds That Pharmaceutical Patent Infringement Settlement Agreement May Deserve Rule-of-Reason Analysis**

The Eleventh Circuit decided that the district court should reexamine whether agreements between a branded pharmaceutical manufacturer and two generic manufacturers to settle patent infringement suits brought by the branded manufacturer should be analyzed under the per se rule or the rule of reason. The district court had held that the per se rule applied.

The agreements in question were between Abbott, the branded manufacturer, and Geneva and Zenith, two generic manufacturers. When Geneva and Zenith planned to enter the market with a drug that would compete with Abbott’s Hytrin drug, Abbott filed patent infringement suits against both. The agreements settling in litigation provided that Abbott’s patent infringement claims would be dismissed, that Zenith and Geneva would not enter the market until another company first introduced a generic product or Abbott’s patents expired, and that Abbott would make substantial payments to both.

Because of the unusual context of the agreement, which appeared to be a horizontal-market allocation agreement, the appeals court believed the district court had been too quick to apply the per se rule. The facts were complicated by the existence of patents, which themselves have exclusionary effects, and by the fact that the agreements arose in the context of settling litigation, which courts generally favor. The
court remanded the case for further consideration of the appropriate standard of analysis to apply.

Valley Drug Co. v. Geneva Pharms., Inc., 344 F.3d 1294 (11th Cir. 2003).

The Eleventh Circuit indicated that the per se rule may not be the appropriate standard in reviewing agreements to settle patent infringement lawsuits.

Maine Health Alliance Settles FTC and State of Maine Price-Fixing Charges
On August 27, 2003, the FTC entered into a consent order with the Maine Health Alliance and its executive director enjoining them from negotiating prices on behalf of both its hospital and physician members. The Alliance, comprised of eleven hospitals and 325 physicians, allegedly negotiated contract prices with several payers operating in the northern Maine area, resulting in significantly higher price than the providers could have negotiated individually.


DOJ Loses and Appeals Dentsply Case
The U.S. District Court for the District of Delaware, after full trial on the merits, rejected the Antitrust Division’s claims under §§ 1 and 2 of the Sherman Act, and § 3 of the Clayton Act, that Dentsply International violated antitrust laws by entering into agreements with its dealers by which they agreed not to handle the products of Dentsply’s competitors. The court agreed with the government’s contentions that Dentsply’s market share was about 80%, that its intent in entering into the exclusive agreements was to foreclose its competitors from the market, and that it had no legitimate efficiency justification for the agreements. The court, however, held that there were a sufficient number of other dealers available to Dentsply’s competitors that its exclusives would not unreasonably restrain competition. In addition, according to the court, nothing prevented current dealers from dropping Dentsply and contracting to sell the products of its competitors. Dentsply, according to the court, had no ability to block new entry, and, indeed, new entry into the market had occurred. The court concluded that “because direct distribution is viable, non-Dentsply dealers are available, and Dentsply dealers may be converted at any time, the DOJ has failed to prove that Dentsply’s actions have been or could be successful in preventing ‘new or potential competitors from gaining a foothold in the market[.]’” The Antitrust Division has appealed the case to the Third Circuit.


The court determined that, because a sufficient number of other dealers were available to defendant’s competitors, exclusive contracts would not restrain competition in violation of antitrust laws.

FTC and Washington University Physician Network Settle FTC Price-Fixing Complaint
On August 22, 2003, the FTC and Washington University Physician Network (WUPN) settled FTC charges that WUPN violated § 5 of the Federal Trade Commission Act by
negotiating prices on behalf of its physician members. WUPN consists of some 900 physician employed by Washington University and 600 community physicians. According to the FTC’s complaint, WUPN negotiated contract prices with payers on behalf of both the faculty and community physicians. The consent order in the case enjoins the collective negotiations and requires WUPN to terminate any payer contracts that the payer requests be cancelled.


**San Diego Anesthesiology Groups Settle FTC Charges**
On July 15, 2003, the FTC entered into consent orders with Anesthesia Service Medical Group, Inc. (ASMG) and Grossmont Anesthesia Services Medical Group (GAS). According to the FTC’s complaints, both groups provide anesthesia services in the San Diego area. ASMG has about 180 physician employees, while GAS has ten. Both groups have staff privileges at Grossmont Medical Hospital in La Mesa, and together, they included about 75% of all anesthesiologists in the area. According to the FTC, the groups agreed not to compete to provide on-call anesthesia services at Grossmont Medical Hospital by agreeing to negotiate with the hospital together and agreeing on the amount of the stipend from the hospital they would accept for providing on-call services. The consent order enjoined this conduct, requiring the groups to negotiate separately with the hospital.

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I. CRIMINAL LAW

Fifth Circuit Vacates Sentence Under Healthcare Fraud Statute For Ex Post Facto Violation

Joyce Hickman was indicted for thirty-two counts of healthcare fraud in violation of 18 U.S.C. §1347, which makes it a crime to knowingly and willfully defraud a healthcare benefit program. A jury convicted Hickman on all counts.

The Fifth Circuit reversed Hickman’s convictions on counts one through three of the first indictment, finding these counts violated the Ex Post Facto Clause because they alleged fraudulent acts that occurred before August 21, 1996, §1347’s effective date. The appeals court rejected the government’s contention that healthcare fraud is a continuing offense and that Hickman’s fraudulent scheme was not complete until she submitted her last false claim in January 1997. Instead, the appeals court determined that each claim Hickman submitted for payment was a separate execution of the scheme. Although Hickman may have grouped them for efficiency, each claim was individually considered and approved. The appeals court explained that, because Hickman submitted and received payment for the claims before §1347’s effective date, her convictions on counts one through three of the first indictment violated the Ex Post Facto Clause. United States v. Hickman, Nos. 02-20174 & 02-20196 (5th Cir. May 16, 2003).

This case suggests that individuals charged with healthcare fraud may be able to avoid criminal liability to the extent a fraudulent claim was submitted prior to the effective date of the law they are charged with violating.

First Circuit Affirms Two-Level Enhancement for Obstructing Medicare/Medicaid Audits

Dana McGovern owned and operated McGovern’s Ambulance Service, Inc. (MAS), which provided transportation for Medicare and Medicaid beneficiaries. Complaints about MAS’ billing practices prompted the Department of Health and Human Services to conduct administrative audits in 1995 and 1998. After federal investigators found MAS had falsely billed Medicare, they expanded their inquiry of MAS’ billing practices. During these audits, McGovern and MAS submitted false “run sheets” to investigators. Following a subsequent federal criminal investigation, McGovern and MAS were indicted on 214 counts alleging violations of the healthcare fraud statute, 18 U.S.C. §1347, money laundering, 18 U.S.C. §1956(a)(1), and obstruction of a federal audit, 18 U.S.C. §1561. McGovern and MAS pled guilty to certain of these counts. At sentencing, the federal district court determined that McGovern was subject to a two-level upward enhancement under U.S. Sentencing Guideline §3C1.1 for obstructing the administrative audits by submitting the bogus run sheets. McGovern appealed the enhancement.
The First Circuit affirmed. The appeals court rejected McGovern’s argument that he was not subject to the enhancement pursuant to note 4(c) because the Medicare and Medicaid administrative audits were not “official investigation[s].” The appeals court held that the key question is not whether the underlying administrative investigation was civil or criminal, but whether the obstructed investigation has a sufficient connection to the offense of conviction.


This decision adopted a liberal interpretation of the U.S. Sentencing Guidelines so as to allow an upward enhancement of a criminal sentence even where the underlying conduct was not originally being reviewed as part of a criminal investigation.

**D.C. High Court Says Defendant Failed to Prove Affirmative Defense of Medical Necessity for Marijuana Use**

Renee Emry, who suffers from multiple sclerosis, entered the office of a U.S. congressman, began smoking marijuana, and was arrested. Emry’s defense at trial to a charge of unlawful possession of marijuana was that her use of marijuana was medically necessary. Emry’s expert witness testified that marijuana was among the drugs generally used to treat the symptoms of multiple sclerosis, and that Emry uses Baclofen and marijuana to control her symptoms. The trial court convicted Emry on the grounds that she was not experiencing symptoms when arrested and that there were legal alternatives to treating her symptoms.

The D.C. Court of Appeals affirmed. In *Griffin v. United States*, 447 A.2d 776 (D.C. 1982), the court had set forth the factors to establish a necessity defense when it stated that, “if there is a reasonable legal alternative to violating the law, a chance both to refuse to do the criminal and also to avoid the threatened harm, the [necessity] defenses will fail.” The appeals court in the instant case held that Emry had the burden to produce evidence to prove each *Griffin* factor. Emry’s expert had stated that there were legal alternatives to treat Emry’s symptoms, and there was nothing in the record to show that Emry had tried all of the legal alternatives. There was also no indication in the record that Emry had smoked the marijuana in the congressman’s office because she was experiencing harm from the symptoms.


This case illustrates the limits of the “medical necessity” defense when legal treatment alternatives exist and no showing of active symptoms is established.

**Second Circuit Says Staging of Automobile Accidents for Medical Payments for Non-Existent Injuries Comes Within Federal Healthcare Fraud Statute**

 Defendants engaged in a scheme in which they participated in several staged automobile accidents and then sought medical benefits for nonexistent injuries. The medical providers billed and received payments from insurance companies, and the medical records were used as evidence in civil suits to obtain payment for the nonexistent injuries under the state No-Fault Act. Defendants received payments for medical expenses and settled with insurance companies after filing civil suits.
Defendants were charged with and convicted of healthcare fraud under 18 U.S.C. § 1347. Defendants appealed.

The Second Circuit affirmed the convictions. Defendants argued that § 1347 applies only to healthcare professionals and that the state no-fault program is not a healthcare benefit program under the statute. The appeals court concluded that § 1347 refers to any person and is not limited to healthcare providers. Furthermore, the appeals court noted that the language of the section as a whole supports the conclusion that Congress intended a broad reading of the statute to cover all kinds of healthcare fraud. The appeals court also noted the legislative history of the act mentions staged automobile and related health insurance fraud.

United States v. Lucien, 347 F.3d 45 (2d Cir. 2003).

This case represents another broad reading of prohibited conduct under a healthcare fraud statute.

Ninth Circuit Says Plaintiffs Have Likelihood of Success on Challenge to Federal Law Barring Cultivation And Use of Medicinal Marijuana

Plaintiffs are California citizens who use marijuana as medical treatment. Physicians for both plaintiffs have stated that they have severe and chronic health problems and are in constant pain and that no other medications or alternative treatments have provided relief. Under the California Compassionate Use Act, seriously ill state citizens may use marijuana for medical purposes if recommended by a physician for the treatment of certain illnesses. The federal Controlled Substances Act (CSA) defines marijuana as a Schedule I controlled substance, deemed to have no medical use and illegal to possess. After one plaintiff was found to be growing marijuana allegedly for her own use, plaintiffs sued, seeking declaratory relief stating that the CSA was unconstitutional and barring its enforcement based on marijuana use for medical necessity. The district court denied relief.

The Ninth Circuit reversed, holding that the CSA was unconstitutional under the facts in this case. In finding the CSA unconstitutional, the appeals court found that raising and using marijuana for medical purposes was not a commercial or economic activity because (1) there was no sale, exchange, or distribution of a product, (2) Congress had exceeded its power under the Commerce Clause because there was no jurisdictional limitation under the CSA, and (3) that allowing plaintiffs to grow a small amount of marijuana for their own use had little effect on interstate commerce. The only factor in favor of the CSA was that there was evidence that intrastate possession of a controlled substance impacts interstate commerce based upon the findings of Congress.

Raich v. Ashcroft, 352 F.3d 1222 (9th Cir. 2003), petition for cert. filed, 72 U.S.L.W. 3674 (Apr. 20, 2004).

This case should be watched, as it is the subject of further appeals to seek constitutionality of the Controlled Substance Act. See also Emry v. United States, 347 F.3d 45 (2d Cir. 2003).
II. FOOD AND DRUG LAW

U.S. Court in Massachusetts Denies Motion to Dismiss State Law Claims in Pharmaceutical Company Pricing Case, Says Claims Were Not Pre-Empted by Medicare Statute or ERISA

Plaintiff union and employee health benefit plans brought a proposed class action alleging that numerous pharmaceutical companies fraudulently overstated the published average wholesale price (AWP) of some prescription drugs. Plaintiffs claimed the results of the overstated AWP were inflated payments for the drugs by Medicare Part B beneficiaries, private health and welfare plans, and other payers. Defendants jointly moved to dismiss the complaint pre-emption by the Medicare Act and the Employee Retirement Income Security Act (ERISA).

The U.S. District Court for the District of Massachusetts denied the motion to dismiss. The court determined that the actions of the pharmaceutical companies, and not the actions of the government, were the cause of plaintiffs’ harm and that the functioning of the Medicare program was not at issue. The court therefore held that the Medicare statute did not pre-empt the state claims. Furthermore, the court held that, because the consumer protection laws are of general application that does not specifically address ERISA plans, there is not a sufficient connection between the state law claims and ERISA to support pre-emption.


This case stands for the proposition that claims alleging the existence of fraudulent pricing schemes may not be pre-empted by the Medicare statute or ERISA, even if the alleged fraudulent pricing scheme could impact the price paid by the Medicare program and ERISA-covered benefit plans.

Third Circuit Upholds Denial of Injunction in Drug Maker’s Trade Dress Infringement Action for Failing to Show Non-Functionality of Drug’s Color and Shape

Shire U.S. Inc. (Shire) sued Barr Laboratories, Inc., in federal district court for trade dress infringement and dilution under the Lanham Act. Shire manufactures and sells Adderall, a drug used in treating attention deficit hyperactivity disorder (ADHD). Adderall tablets come in either blue or pale orange/peach and are round or oval in shape, depending on strength. The tablets are stamped with the mark “AD” on one side and the dosage on the other. Barr developed a generic alternative to Adderall. Barr’s drug comes in blue or orange/peach tablets that are oval and convex in shape. The color and size of Barr’s tablets, which have a “b” mark or the company’s trade name, are linked to dosage. According to Shire, Barr’s generic drug copied the appearance of its branded version, which amounted to unfair competition and diluted Shire’s rights. Shire moved for a preliminary injunction, which was denied. Shire appealed.
The Third Circuit affirmed, finding no clear error in the district court’s conclusion that Shire “has not credibly rebutted Barr’s theory that the similar color-coding and shape of the products are particularly meaningful for ADHD patients and enhance efficacy.” Trade dress protection extends only to incidental or arbitrary features that identify a product’s source. Shire failed to meet its burden based on the affidavits of several experts that the distinctive colors and shapes of the tablets “enhance patient safety and compliance with the medically prescribed dosing regimen” by acting as an identifying mechanism, which is important for ADHD patients. Moreover, while the two tablets were similar, they were not identical because Barr had not copied the specific markings signifying the Adderall source. 


*This case demonstrates that a claim for trade dress dilution and infringement is more likely to fail if there is a valid clinical reason for using a similar color and shape on a product, particularly if the markings on the product are not identical to those on the product of the manufacturer that pursues the infringement claim.*

**Second Circuit Says Holds Plaintiffs’ Claims for Damages Were Caused Directly by Defendant’s Alleged Fraud**

Warner-Lambert Co. manufactured a new drug, Rezulin, for the treatment of diabetes. After a number of patient deaths and a request for withdrawal by the Food and Drug Administration, Warner-Lambert withdrew Rezulin from the market in 2000. In 2001, a group of plaintiffs sought class relief against Warner-Lambert for all health benefit providers who had paid for Rezulin. Plaintiffs sought to recover the money they had spent on Rezulin based on Warner-Lambert’s knowing concealment, suppression, or omission of material facts under the New Jersey Consumer Fraud Act, breach of express warranties and of the implied warranty of merchantability, and unjust enrichment. Warner-Lambert moved to dismiss the complaint. The district court granted the motion, concluding that plaintiffs had not established that Warner-Lambert’s actions were the proximate cause of their damages. Plaintiffs appealed.

The Second Circuit vacated the district court’s dismissal of plaintiffs’ claims. Plaintiffs alleged that the injury was direct to them because they would not have bought Rezulin had it not been for Warner-Lambert’s misrepresentations, when there were cheaper, safer alternatives on the market. Rejecting the district court’s characterization of plaintiffs as financial intermediaries and not direct purchasers of Rezulin, the appeals court determined that, in this case, plaintiffs were purchasers because they had a right to recover from drug companies amounts that were overpaid due to deceptive marketing practices. The appeals court concluded that the injury plaintiffs complained of directly impacted them, and they had provided sufficient evidence that Warner-Lambert had engaged in deceptive marketing practices. 


*This case provides that a healthcare provider may have a cause of action against a drug company even if the healthcare providers were not the direct purchasers of the drug at issue.*
Fourth Circuit Rules That Government and Vaccine Manufacturer Could Not Be Held Liable for Contribution Because No Evidence Was Presented to Show Vaccine Caused Injury

Plaintiff Danny Callahan, a three-month-old child, was treated by employees of Saint Louis University (SLU) for a fever and a perirectal abscess. Danny had received a dose of Orimune, an oral polio vaccine, one month earlier. While the abscess improved with treatment, Danny’s legs and left arm were permanently paralyzed. Doctors ultimately concluded that Danny had vaccine-associated polio. The Callahans (plaintiffs) sued SLU, claiming that Danny had been improperly treated when he was given the wrong antibiotic to treat the abscess. Plaintiffs claimed the improper treatment allowed endotoxins to be released into Danny’s system, which suppressed his immune system and allowed the polio virus to replicate. A jury awarded $16 million to plaintiffs, which was affirmed on appeal. SLU sought contribution for the award from American Cyanamid as the parent company of the vaccine manufacturer and from the government for regulatory violations in approving the vaccine. The court granted summary judgment in favor of Cyanamid and against the government.

The Fourth Circuit affirmed the district court’s summary judgment for Cyanamid, because SLU failed to present evidence that excessive neurovirulence, which was the defect in the vaccine, was the proximate cause of Danny’s injury. The Fourth Circuit reversed and remanded the district court’s summary judgment that the government owed SLU contribution. The appeals court agreed with the government that SLU presented no evidence that its violation of the vaccine regulations proximately caused Danny’s injury.


This case illustrates the importance of establishing evidence of a causal link between a vaccine and any alleged injuries in seeking contribution from a vaccine manufacturer.

U.S. Court in Illinois Says Regulatory Scheme for Pre-Market Approval of Medical Device Was Not Unconstitutionally Vague

The government filed a nineteen-count indictment charging AbTox officers with selling an adulterated sterilizer that had not been submitted for pre-market notification. The indictment alleged that defendants conspired to sell the sterilizer to government agencies and represented that the sterilizer was approved by the Food and Drug Administration (FDA). Defendants moved to dismiss, arguing that (1) their due process rights had been violated because the FDA regulatory scheme was vague, (2) “the conspiracy count was duplicitous,” (3) the two wire-fraud counts failed “to allege use of the wires,” and (4) “false-statement count ten was based on fundamentally ambiguous questions.” The government filed a superseding indictment that properly alleged the use of wires for the wire fraud counts.

The U.S. District Court for the Northern District of Illinois denied the motion to dismiss. The court rejected the vagueness claim and held that an “as-applied” determination requires factual determinations that are not appropriate for a court to determine on a
pre-trial motion. The court then concluded that the indictment alleged all of the elements of a single conspiracy plus the overt acts, which were part of the same conspiracy. Therefore, the court denied the motion to dismiss the conspiracy count. Defendants also argued the FDA Act and regulations that prohibit the use of products for uses that the FDA has not approved, also known as off-label use, violated the First Amendment. The court found the FDA’s prohibitions reasonable and found no less burdensome alternative and, therefore, denied the motion to dismiss on that ground. **United States v. Caputo,** 288 F. Supp. 2d 912 (N.D. Ill. 2003).

This case illustrates a broad interpretation of the FDA’s authority to regulate marketing of medical devices and off-label use.

**Oregon Appeals Court Finds Some Punitive Damages Appropriate in Negligent Misrepresentation Verdict**

Plaintiff was treated by a physician who knew he was taking an asthma medication but did not believe plaintiff could develop a toxicity problem from taking the drug. Shortly after Edwards sent him home, plaintiff was admitted to the emergency room and suffered seizures resulting in permanent brain damage. In plaintiff’s subsequent lawsuit, Edwards cross-claimed against the Key Pharmaceuticals, Inc. (Key), claiming that Key had fraudulently misrepresented its product’s toxicity. The jury awarded Edwards $500,000 in compensatory damages and $22.5 million in punitive damages. Plaintiff was awarded $5 million in compensatory damages and $35 million in punitive damages. Key argued that the combined damages for both parties were excessive and unconstitutional. On remand, the appeals court held the awards were not excessive. The Oregon Supreme Court denied review, and Key petitioned for a writ of certiorari to the U.S. Supreme Court. During that time, the U.S. Supreme Court decided **State Farm v. Campbell,** 123 S. Ct. 1513 (2003), and remanded the case for reconsideration.

The Oregon Court of Appeals vacated the punitive damages award and held that the appropriate amount was seven times the compensatory damages, applying a three-factor test set forth in **BMW of North America, Inc. v. Gore.** The three **Gore** factors are: “(1) the degree of reprehensibility of the defendant’s misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.” **Bocci v. Key Pharm., Inc.,** 76 P.3d 669 (Or. Ct. App. 2003).

This case sets forth a likely framework courts may use when applying the Supreme Court’s tests to evaluate allegedly “excessive” punitive damage awards.

**U.S. Court in Massachusetts Denies Motion to Dismiss RICO, Antitrust Claims in Action Alleging Pharmaceutical Companies Illegally Inflated AWPs**

Plaintiffs in a proposed class action alleged Racketeer Influenced and Corrupt Organizations Act (RICO) and antitrust violations consisting of fraudulent inflation of the average wholesale price (AWP) by a number of pharmaceutical manufacturers and four pharmacy benefit managers (PBMs). Plaintiffs alleged that the overstated AWPs
resulted in inflated payments for the drugs by Medicare Part B beneficiaries (through co-payments), private health and welfare plans, and other end payers.

The U.S. District Court for the District of Massachusetts found that plaintiffs had sufficiently alleged a RICO enterprise between each drug manufacturer and each PBM with the common fraudulent purpose of a falsely-inflated AWP. Plaintiffs alleged that PBMs benefited from AWP inflation by pocketing the spread between the published AWPs and actual costs. Manufacturers benefited from the spread because it encouraged PBMs to sell their drugs over those of their competitors. The court also concluded that plaintiffs had sufficiently described systematic links, common communication networks, and regular meetings between the manufacturers and the PBMs.

The court refused to dismiss the complaint based on defendants' contention that plaintiffs had failed to aver fraud with particularity pursuant to Fed. R. Civ. P. 9(b). Given the allegations and concessions of an industry-wide practice of inflating AWPs, the court explained that plaintiffs were not required to allege a specific spread for each drug, so long as plaintiffs alleged sufficient facts to infer a fraudulent scheme by each particular defendant manufacturer.


A proposed class action suit alleging fraudulent inflation of the AWP of some prescription drugs may proceed with claims under RICO and antitrust laws.

III. FALSE CLAIMS

Ninth Circuit Affirms Qui Tam Relators Were Not Entitled to Share of Settlement in Action Against State-Run Hospital System Under False Claims Act

Two individuals brought a qui tam action under the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, against the University of California’s teaching hospitals, alleging fraudulent billing of federal and state health insurance programs for services by interns that were billed as if faculty physicians had provided the services. The teaching hospitals were audited, and a settlement with the government was negotiated. During negotiations, the government intervened in the qui tam actions. The relators were notified of the settlement, and did not object, and the government moved to dismiss both cases. The government began negotiations with the relators about the amount of the settlement that was owed to them, but terminated the negotiations based on Vermont Agency of Natural Resources v. United States ex rel. Stevens, 529 U.S. 765 (2000), claiming that Stevens negated any statutory right the relators had to a share of the settlement. The relators moved for a share of the settlement proceeds. The district court denied the motion, and the relators appealed.

The Ninth Circuit affirmed. The appeals court determined that the plain language of the FCA precluded the relators’ claims because a state entity is not a “person” for purposes
of § 3729; therefore, the relators had no statutory basis for bringing suit under § 3730(b)(1). The court emphasized that the government must share settlement proceeds under § 3730(d)(1) only if the private party had a valid cause of action under § 3729(a), which was foreclosed in this case because the university was a state entity.  

**Donald v. University of Cal. Bd. of Regents**, 329 F.3d 1040 (9th Cir. 2003).

*This case demonstrates that a qui tam relator may not share in settlement proceeds in a qui tam action involving a state entity that was settled after the Supreme Court’s decision in Stevens, even if the qui tam action was initiated prior to the issuance of the Stevens decision.*

**Eighth Circuit Finds Relator Not Original Source of Information Underlying Ambulance Billing Fraud Claims**

James Kinney, a paramedic for Hennepin County Medical Center (HCMC), filed a qui tam action under the False Claims Act (FCA) against HCMC and Hennepin Faculty Associations (HFA) in federal district court. Kinney claimed that HFA physicians who signed ambulance run sheets falsely certified that all ambulance services were medically necessary. The government declined to intervene. The district court dismissed the action against HCMC and granted summary judgment to HFA. Kinney did not appeal the dismissal but instead filed a second qui tam action against HCMC employees (defendants). Defendants moved to dismiss, arguing the claims came from information publicly disclosed during the first action. The district court dismissed the action, finding that Kinney did not have “direct knowledge” of the allegations because he received the information from the depositions of defendants in the first action. Kinney appealed.

The Eighth Circuit affirmed, finding a lack of subject matter jurisdiction because Kinney was not an original source. Citing the Fed. R. Civ. P. 9(b) requirement that claims brought under the FCA must be “stated with particularity,” the appeals court found no evidence in the record that Kinney had “direct and independent knowledge” of the facts underlying the allegations against defendants. In the first qui tam action, Kinney had alleged that the HFA physicians were responsible for the fraud and made no mention of defendants’ alleged role. Had Kinney known of any involvement on defendants’ part in the alleged fraud, he would have been obligated to include them in his initial complaint, the appeals court found.  


*This case illustrates the importance of pleading all potential claims known to a qui tam relator in a complaint filed under the False Claims Act.*

**Fourth Circuit Affirms Convictions for Medicaid Fraud Scheme, Vacates and Remands Sentences for Recalculation of Loss Amounts**

Glennis and Clifford Bolden (defendants) were indicted by a grand jury in North Carolina and charged with an elaborate fraud scheme to improperly bill North Carolina’s Medicaid program. Defendants carried out the scheme through Emerald Health Care-Taylorsville (Emerald Health), a nursing facility owned by Glennis’ father.
In November 1998, defendants were convicted of multiple offenses after a jury trial, including mail and wire fraud, submitting false claims to the government, and money laundering. Defendants were sentenced, fined, and ordered to pay restitution. Defendants appealed.

The Fourth Circuit affirmed the convictions, but reversed and remanded their sentences in part for recalculation. Defendants argued that the evidence was insufficient to prove that the money laundering offenses involved proceeds of an unlawful activity, because the money laundering transactions occurred prior to the unlawful activity of submission of false Medicaid cost reports. In rejecting this contention, the appeals court explained that the money laundering statute does not require the underlying criminal activity to be completed prior to the money laundering transactions. Because the Medicaid fraud scheme was ongoing before the submission of the mail transactions, the appeals court found that there was sufficient evidence that defendants' scheme produced proceeds through the prospective payments system, which was the underlying activity supporting the fraudulent financial transactions. Therefore, there was sufficient evidence to support the money laundering convictions. 


*This case stands for the proposition that a provider may be convicted of money laundering even if the underlying criminal activity had not been completed prior to the money laundering transactions.*

**Eighth Circuit Modifies Fine in False Claims Suit, Holds Whistleblower Was Not Original Source of Most Claims**

Plaintiff, an employee of St. Francis Health Services (SFHS), sent whistleblower letters to the Minnesota Department of Human Services (DHS). After SFHS company officials learned of plaintiff’s letters, he was fired. Based on the letters, DHS audited SFHS facilities and made several downward adjustments for noncompliance with Medicaid reimbursement rules. Plaintiff filed a claim of retaliatory discharge, and qui tam claims, under the False Claims Act. The jury found SFHS had submitted false claims and fined the company $1.6 million. The jury also found that plaintiff had been fired in retaliation. Defendants appealed.

The Eighth Circuit reversed the judgment of the district court in part and remanded the case for modification, on the ground that plaintiff was not the original source of many of the false claims allegations. Noting that it was undisputed that plaintiff had obtained copies of the DHS audit reports, the appeals court held that Medicaid audit reports prepared by a state agency authorized to administer a Medicaid program are public disclosures within the jurisdictional bar. Plaintiff argued that he was the original source of the information in the DHS audit reports because, without his whistleblower letters, the DHS would not have conducted the audit. The court rejected plaintiff’s “catalyst theory” and concluded that, because plaintiff was the original source of only one allegation, the total fine had to be vacated except for the amount attributable to the one claim.
This case stands for the proposition that a qui tam relator cannot recover under the False Claims Act if the relator based his claims on an audit report prepared by the Medicaid state agency, even if the audit was initiated due to information provided to the agency by the relator.

Fifth Circuit Holds HMO’s Disregard of Government Regulations Did Not Create Liability

Humana had contracts with the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), to provide services to Medicare beneficiaries through its health maintenance organization (HMO). The relator worked for Humana as a sales representative until he was fired in 1998. In 1999, the relator filed a qui tam complaint under the False Claims Act, alleging Humana had engaged in a cherry picking scheme in which it discouraged people in rural areas and unhealthy people from joining Humana’s HMOs. The relator also claimed Humana entered into contracts to serve outlying counties as required by HCFA in order to have access to the profitable Houston market, but that Humana had no intention of actually enrolling participants in those counties. The government declined to intervene in the case. The district court granted Humana’s motion to dismiss, and the relator appealed.

The Fifth Circuit affirmed. The appeals court held that Humana’s disregard for government regulations did not create liability. The appeals court held that relator’s implied certification argument failed because the relator failed to allege the contracts for services to Medicare beneficiaries had any references to regulations concerning discrimination and because the relator failed to allege that Humana did in fact implement a policy of discouraging undesirable enrollees. The appeals court agreed with the district court’s determination that the relator’s one-sentence inducement allegation failed to cite any specific facts supporting the claim and only stated the requisite intent in a general way. The relator also failed to allege that any applicable regulation had been violated.

United States ex rel. Willard v. Humana Health Plan, 336 F.3d 375 (5th Cir. 2003).

This case suggests that merely alleging an implied certification of compliance with applicable rules without more specific allegations will not support a qui tam action.

Ninth Circuit Says Judgment in Medicare False Claims Case Was Not Excessive

Medicare pays for physical therapy services when provided by or under the supervision of a physician or by a physical therapist in independent practice. Defendant, who was neither a physician nor a physical therapist, used his father’s personal identification number (PIN) to submit bills for physical therapy services. The United States brought a False Claims Act (FCA) action against defendant for submitting $331,078 in false claims, but only sought damages for the claims that exceeded the applicable cap for a total of $58,151.64. The district court found defendant had knowingly submitted false claims to Medicare and awarded treble damages of $174,454.92. The district court also awarded FCA fines of $550,000, for a total judgment of $729,454.92. On appeal, the
case was remanded for the district court to consider the constitutionality of the judgment under the Eighth Amendment Excessive Fines Clause (Mackby I). On remand, the district court held that judgment was not “grossly disproportional to the gravity of a defendant’s offense” because of the significant harm the false claims caused the government, defendant’s knowing submission of the claims with his father’s PIN, and the fact the maximum penalty would have been nearly $85 million.

The Ninth Circuit noted that in Mackby I it had found the damages and penalty to be, in part, punitive, and thus subject to a determination of whether the fine was unconstitutionally excessive. Weighing defendant’s knowing use of his father’s PIN, the damage to public confidence in the system, and the potential maximum fine, the court upheld the judgment.

**United States v. Mackby,** 339 F.3d 1013 (9th Cir. 2003).

*This decision suggests that despite Mackby I’s holding that FCA penalties must be reviewed under the Eighth Amendment’s Excessive Fines Clause, a defendant faces significant obstacles to establishing that a fine is excessive.*

**U.S. Court in District of Columbia Holds That Fraudulent Scheme Came Within Healthcare Fraud Statute**

The federal government indicted Keith Beard and others (collectively “defendants”) on one count of healthcare fraud under 18 U.S.C. § 1347, and several other counts of mail fraud and conspiracy. Beard moved to dismiss the § 1347 healthcare fraud count. The indictment charged defendants with a scheme to defraud Kaiser Foundation Health Plan, Inc. (Kaiser), a nonprofit health maintenance organization and healthcare benefit program, by submitting false invoices to Kaiser for dental chairs. Defendants argued that § 1347 does not apply to the scheme that was alleged in the indictment, and the government argued the plain language of the statute does not limit the type of healthcare fraud that can be charged.

The U.S. District Court for the District of Columbia denied Beard’s motion to dismiss. The court noted § 1347 provides that anyone who executes a scheme “to defraud any health care benefit program” or obtain by fraud any property owned by any healthcare benefit program “in connection with the delivery of or payment for health care benefits, items, or services” shall be fined or imprisoned. The court concluded that Congress chose language consistent with the intent to “combat fraud perpetrated against health care providers and programs.” The court explained that the fraud committed against Kaiser was in its role as a healthcare benefit program, and that defendants sought to obtain payment from Kaiser in connection with healthcare items, which was the type of fraud covered by § 1347.


*This case suggests that the federal fraud statues will be read broadly where a connection can be established between fraudulent conduct and payment for healthcare items.*
Sixth Circuit Holds Relator Entitled to Share of Government Settlement with Health System Even Though Government Did Not Intervene in Qui Tam Action

A settlement pursued by the government in lieu of intervening in a qui tam action asserting the same False Claims Act (FCA) claims constitutes an “alternate remedy” and entitles a relator to a share of the proceeds, the Sixth Circuit ruled. While agreeing with a lower court decision to dismiss the relator’s action because he failed to plead his FCA claims with sufficient particularity, the appeals court also held that the relator should be given the opportunity to amend his complaint so as to comply with Fed. R. Evid. 9(b). The appeals court found, however, that certain allegations in the complaint were barred because they were, in part, “based upon” public disclosures. If the relator can satisfy the requirements of Rule 9(b), the district court must then determine whether the conduct contemplated in the government’s settlement agreement overlaps with the conduct alleged by relator in bringing the qui tam action, the appeals court explained.

The appeals court concluded that the settlement agreement between the government and Community Health System constituted an “alternate remedy” under 31 U.S.C. § 3730(c)(5) that would entitle a relator to a share of the proceeds. Section 3730(c)(5) provides that the government may pursue its claim through any available alternate remedy and “the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section.”


This case held that the interpretation of a relator’s right to share in a government recovery as applying only when the government intervenes in a qui tam action did not comport with the plain language of the FCA.

Third Circuit Says DHHS OIG Has Authority to Conduct PATH Audits of Teaching Hospitals

The Third Circuit held that the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) can move forward with its Physicians at Teaching Hospitals (PATH) audits. The appeals court also affirmed a lower court’s order enforcing certain administrative subpoenas issued by the OIG after the University of Medicine and Dentistry of New Jersey (University) refused to go ahead with the audit and moved to enjoin the OIG from doing so. According to the appeals court, “the PATH audits are of a kind that is squarely within the broad authority of the inspector general to audit providers for the purpose of preventing fraud and abuse within the Medicare program.” The appeals court also agreed with the lower court that it lacked jurisdiction over the University’s action to enjoin the audits. The appeals court concluded that the action was not “fit” for judicial review because the OIG had only initiated an investigation and had yet to take a final enforcement action. “While the hospitals have raised profoundly serious questions about the wisdom and fairness of the PATH audits, the audits are within the broad authority of the inspector general, and any challenges are properly made when they have led to action against the hospitals and their employees, if any,” the appeals court wrote. Although some healthcare providers complained that the PATH
audits amounted to a retroactive application of the 1996 rule, the OIG contended that the rules had always required the physician’s physical presence for Part B payments. University of Med. and Dentistry v. Corrigan, 347 F.3d 57 (3d Cir. 2003).

This decision upholds a controversial audit initiative that has withstood several prior challenges of its legitimacy.

U.S. Court in Indiana Says ER Physician Alleged Sufficient Facts to Survive Dismissal of FCA Retaliation Claim Against Hospital And Medical Group

Plaintiff filed suit against Logansport Memorial Hospital (Hospital) and the Logan Emergency Physicians (LEP), asserting a retaliation claim under the False Claims Act (FCA) whistleblower provisions, 31 U.S.C. §3730(h). LEP removed plaintiff from the emergency room schedule at the Hospital after he informed patients that “it was inappropriate for them to come to the emergency room for colds and non-emergency medical conditions.” Plaintiff had filed a report to the state about the alleged Medicare/Medicaid fraud and abuse before being terminated and informed LEP of his concerns.

The U.S. District Court for the Southern District of Louisiana found that the allegations by plaintiff that he told the LEP president that he would continue to report abuses of Medicare and Medicaid as required by federal law were sufficient to (1) notify the Hospital and LEP that there was a distinct possibility of a qui tam action and (2) demonstrate that the defendants had knowledge that plaintiff was engaged in protected conduct. Therefore, the court found sufficient facts were pled to support a retaliation claim and refused to dismiss the case under the FCA. Chomer v. Logansport Mem’l Hosp., 2003 WL 23009014 (S.D. Ind. Oct 29, 2003).

Once a provider is on notice that potential False Claims Act violations are being reported, the provider has sufficient notice of a potential qui tam action such that the provider must not take steps that could be considered retaliation for filing such a claim.

Fifth Circuit Says Admission of Evidence from Medical Board Proceeding Was More Probative Than Prejudicial

Dr. James T. Parsons was indicted on twenty-three counts of healthcare fraud based on his submission of Medicare and Medicaid claims for office visits that never occurred and services that were not provided. Parsons raised a defense of mistake or accident and claimed that his office staff was disorganized. The trial court, despite Parson’s objection, allowed the government to introduce evidence that the State of Texas Board of Medical Examiners had warned Parsons to adequately supervise his office staff and that his patient files were substandard. A jury found subsequently found Parsons guilty on all counts.

The Fifth Circuit affirmed the trial court’s judgment. The appeals court found that the lower court properly allowed the government to introduce the warning, without allowing the entire report and findings of fact, because the warning demonstrated that Parsons
was on notice about the problems and negated his defense of mistake or accident and thus was more probative than prejudicial.


A medical board’s notice of a need for adequate supervision is admissible and negates a healthcare fraud defense based on mistake or accident.

**Fifth Circuit Says Plaintiff Sufficiently Alleged False Claims to Survive Motion to Dismiss**

Plaintiff brought a False Claims Act qui tam action against her former employer St. Luke’s Episcopal Hospital and others (collectively “defendants”), alleging the submission of bills for services that were either medically unnecessary or performed by an unlicensed physician. The district court dismissed the action for failure to state a claim. Plaintiff appealed.

The Fifth Circuit reversed, finding that plaintiff had sufficiently alleged that defendants knowingly ordered services that were not medically necessary and engaged in a scheme of unnecessary admissions and artificial upgrades in patient status. Hospital and physician defendants each argued that the other had control over the billing. The appeals court determined that plaintiff sufficiently alleged that all defendants participated in the scheme together, and thus the complaint was adequate on that issue as well. With regard to the unlicensed physician, the appeals court disagreed with defendants’ assertion that plaintiff alleged only the unauthorized practice of medicine and not a false claim, finding that plaintiff alleged that physician defendants had warranted and represented in their statement of services that services were rendered by a licensed physician, and therefore those billings were based on a false claim. Plaintiff also claimed that the hospital defendants were aware of the unlicensed physician and its claims based on his services were also false.


Billing for provision of unnecessary services or services by an unlicensed provider may be sufficient basis for a claim under the FCA.

**First Circuit Affirms Dismissal of Whistleblower’s FCA Action Against Hospital for Failure to Plead Fraud with Particularity**

The relator initiated a qui tam action against Melrose-Wakefield Hospital (Hospital), alleging that he had observed and reported numerous instances of substandard care, inadequate quality control, and failure to meet regulatory standards required for Medicare and Medicaid reimbursement. The Hospital moved to dismiss for failure to state a claim. The district court granted the motion, finding that the complaint failed to set forth allegations of fraud with particularity.

The First Circuit affirmed. Although Fed. R. Civ. P. 9(b) allows knowledge of fraud to be averred generally, the appeals court emphasized that a relator must still plead with particularity a defendant’s presentation of a false or fraudulent claim to the government.
The appeals court refused to extend relaxed pleading, which allows plaintiffs to make general averments at the outset and amend their complaints after discovery, to actions under the False Claims Act (FCA), despite the relator’s claim that the Hospital possessed and controlled the information needed to plead the alleged fraud with particularity. In a qui tam action under the FCA, the government, as the real party in interest, is given the opportunity to intervene based on the original complaint. The appeals court observed that a qui tam relator who has suffered no injury might be more likely to file suit as “a pretext to uncover unknown wrongs.” The appeals court also rejected the relator’s retaliation claim for failure to “allege a factual predicate concrete enough to support his conclusory statement that he was retaliated against because of conduct protected under the FCA.”


A qui tam relator may not present general allegations in lieu of details of actual false claims in the hope that such details will emerge through subsequent discovery.

IV. SELF-REFERRAL

CMS Releases Phase II Stark Rule
CMS published the long-delayed “Phase II” final rule under the Stark Law on March 26, 2004, as an interim final rule with comment period. The new rule, set to take effect on July 26, 2004, contains several welcome improvements and new exceptions, although some aspects of the Phase II rule have the effect of narrowing other exceptions under the Stark Law in a way that may jeopardize existing arrangements. Highlights of the rule include:

- Tightening of rules on in-office ancillary services and shared facilities
- New rules on physician recruitment and retention
- Flexibility in physician compensation and other contracting terms
- Clarification of indirect financial relationships
- Reduced reporting obligations, but increased documentation requirements
- New exceptions for professional courtesy; charitable donations; obstetrical malpractice insurance subsidies (mirroring the OIG safe harbor)
- Grace period for temporary lapses in compliance (offers up to 90 days of protection for certain previously Stark-compliant arrangements that fall out of compliance for reasons beyond the control of the DHS provider)
- Community-wide health information systems
- Permission of certain intra-family rural referrals
- Expansion of exception for public company investments
- Expanded definition of academic medical centers

V. ADVISORY OPINIONS

DHHS OIG Says It Will Not Impose Sanctions Related to Joint Venture Ownership of Freestanding MRI Center Located on Campus of Rural Community Hospital
The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) said that it would not impose sanctions relating to a rural joint venture ownership of a freestanding magnetic resonance imaging (MRI) center that fits in neither the small entity safe harbor nor the rural entity safe harbor. The venture is owned by a hospital and its supporting foundation (30%), persons in a position to refer or otherwise provide services at the MRI venture (30%), and various community members and others not in a position to influence referrals (40%). Investors generated approximately 37% of the MRI Center’s revenues in 2000 and 2001; approximately 24% of total revenues were generated by the Hospital, which contracts with the center for MRI services, while approximately 13% of total revenues were generated by investing physicians. Disinterested parties generated the center’s remaining revenues (over 60% of the total).

In declining to impose sanctions, the OIG considered the following to be most significant:
• The Arrangement possesses indicia of a legitimate, bona fide business. All potential investors, both physicians and non-physicians, were offered the opportunity to purchase investment interests on the same terms and conditions. Less than 40% of revenue of the MRI Center is derived from business generated by interested investors.
• The structure of the Arrangement comports with then-extant guidance related to the application of the anti-kickback statute to rural joint ventures.
• The MRI Center serves a large majority of rural patients, many of whom are elderly or indigent patients for whom travel to a distant MRI facility would be a hardship.
• The Management Agreement and Space Lease comply with the relevant safe harbors.

DHHS OIG Finds Minimal Risk of Fraud and Abuse Related to Emergency Helicopter Transports of Trauma Patients
The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) said that it will not impose sanctions related to a Proposed Arrangement under which a nonprofit, rural-area Hospital will provide a helicopter landing pad, crew quarters, and related resources without charge to a for-profit ambulance company. Trauma victims in area in which the Hospital is located experience higher rates of mortality and disability than trauma victims in other parts of the state, because of the geographic distances between appropriately equipped emergency rooms in the area, inadequate ground ambulance coverage, and long response time by emergency personnel.

According to the OIG, the proposed arrangement, implicates the Anti-Kickback Statute, but there is minimal risk of federal healthcare program abuse. The OIG also found that the Proposed Arrangement would provide significant benefits to the community. The OIG found that the Proposed Arrangement:
• Would relate to emergency medical services only.
• Does not preclude other hospitals in the area from having helicopter landing pads as part of their facilities and does not preclude the ambulance company from delivering patients to those hospitals.
• Would function in the context of a State-supervised, coordinated emergency services effort to integrate and improve the emergency medical services and trauma care system in the area and throughout the State.
• Would likely have a positive impact on the quality of patient care in the area as well as on timely access to care.

The OIG cautioned that the benefits to the community “are specific to this heavily-regulated, State-supervised emergency air ambulance service and would not justify other arrangements between hospitals and ambulance suppliers.” 

DHHS OIG Says It Would Not Impose Administrative Sanctions in Relation to Proposed Reintegration of Medical Group and Hospital
The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) stated that it would not impose sanctions in relation to the proposed reintegration of a medical group (Group), which had donated a hospital to a nonprofit corporation in 1932, and the Hospital. The Group employs twenty-one physicians (including the thirteen Group shareholders), two nurse practitioners, a podiatrist, and other health professionals. The OIG considered the Group’s retirement plan and trust to be part of the Group. The reintegration will involve several processes, including the Group’s transfer of its assets to the Hospital in exchange for the amount necessary to satisfy all encumbrances related to the transferred assets, up to a preset payment cap, and the Hospital’s provision of meaningful representation on the Hospital’s Board of Directors to the Group. The Hospital and the Group will enter into a ten-year professional services agreement (PSA) to staff a new Hospital outpatient clinic and the emergency department. The Hospital will have the exclusive right to bill patients and their third party payers and will pay the Group a fee, which will be consistent with fair market value in an arms-length transaction for services rendered. Patients seen by the Group at the Hospital’s clinic will be largely the same patients the Group is currently treating in its existing private practice.

The OIG concluded that “the most obvious remuneration—the transfer of the Group’s assets to the Hospital—flows in the same direction as the most obvious referral pattern—the physicians’ referrals of their patients to the Hospital.” The OIG further concluded that neither party would likely generate impermissible remuneration to the other party.
DHHS OIG Declines to Impose Civil Monetary Penalties in Relation to Waiver of Cost-Sharing Obligations for Certain Self-Monitored Blood Glucose Equipment and Supplies

The Requestor, a nationwide supplier of blood glucose testing products, will provide self-monitored blood glucose (SMBG) supplies to BARI 2D patients and seek reimbursement from the Medicare and Medicaid programs or other insurance programs. BARI 2D is a randomized clinical trial run by the National Heart, Lung, and Blood Institute (NHLBI). Neither the Requestor nor the manufacturer was involved in the planning of the BARI 2D protocol or the determination of the frequency of SMBG testing. Under the Proposed Arrangement, for Medicare patients, the Requestor would waive Part B cost-sharing obligations for SMBG supplies.

The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) said it would not impose civil monetary penalties because “the Proposed Arrangement reasonably accommodates the needs of an important, government-sponsored scientific study without posing a significant risk of fraud and abuse.” The OIG considered such factors as (1) NHLBI controls the determination of the strategic clinical questions to be resolved through the study, the types of drugs and supplies to be used in the study, and the detailed treatment protocol to be followed by the study, (2) NHLBI has selected all of the study’s Clinical Centers in accordance with its own specifications, and (3) unlike many privately sponsored clinical trials, BARI 2D is not intended to develop, study, or benefit any specific commercial product.

The OIG cautioned, however, that its view of private studies would be different. Specifically, the OIG noted that, because “commercial or private studies pose significantly different risks under the NCD and the Medicare fraud and abuse authorities, routine waivers of cost-sharing obligations to enrollees in such studies would not necessarily be sheltered from civil monetary penalties . . . .” Advisory Op. No. 04-01 (Dep't Health and Human Servs. Office of Inspector Gen. Feb. 9, 2004).

DHHS OIG Finds Proposed Waiver of Cost-Sharing Obligations by Municipality Owned Ambulance Service Would Not Generate Prohibited Remuneration Under Anti-Kickback Statute

A municipal Fire Department that owns and operates an ambulance service proposed to treat revenue received from a special utility assessment as payment of otherwise applicable coinsurance and deductibles due from residents. The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) concluded that the Proposed Arrangement would not generate prohibited remuneration under the Anti-Kickback Statute and that it would not impose administrative sanctions.

The City adopted an ordinance under which the Fire Department’s emergency medical services would be funded through billing for services provided and a monthly utility fee placed on residents’ water bills. The ordinance authorized the billing of residents or their insurers, including Federal healthcare programs, only to the extent of their insurance coverage and treats the revenues received from the utility fee as payment of any otherwise applicable co-insurance and deductibles due from the residents. In finding no
threat of prohibited remuneration, the OIG referred to Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual Chap. 16, § 50.3, which provides: “a [state or local government] facility which reduces or waives its charges for patients unable to pay, or charges patients only to the extent of their Medicare and other health insurance coverage, is not viewed as furnishing free services and may therefore receive program payment.” The OIG read the word “facility” to include a municipality owned ambulance service.

The OIG imposed the following limitations on when it would not impose sanctions: (1) the sole criterion for the cost-sharing waiver is residency, and (2) a governmental unit is the ambulance supplier. The OIG emphasized that this ruling would not apply to contracts with outside ambulance suppliers.

Progress on Electronic Health Records
On July 1, 2003, the College of American Pathologists announced that it had signed a $32.4 million, five-year sole source contract with the National Library of Medicine (NLM) to license English and Spanish language editions of SNOMED Clinical Terms®. The agreement is of major significance for three reasons. First, SNOMED’s uniform terminology is believed to be fundamental to developing a standardized electronic health record. Second, the agreement is widely perceived as an outgrowth of the President’s support for an improved healthcare information infrastructure. Third, the agreement demonstrates the role the government can play in both adopting and disseminating standards for the development of healthcare information infrastructure.

Starting in January, 2004, free-of-charge access to SNOMED CT core content and all version updates will be available through the NLM’s Unified Medical Language System (UMLS) Metathesaurus, a knowledge source containing biomedical concepts and terms from many controlled vocabularies and classifications.

CMS Issues Enforcement Guidance for Transactions and Code Sets
On July 24, 2003, the Centers for Medicare and Medicaid Services (CMS) held an audio-conference to describe simultaneously released enforcement guidance for post-October 16th noncompliance with the Health Insurance Portability and Accountability Act’s (HIPAA) transaction and code set regulations. The guidance is significant in at least two ways. First, it documents an underlying reality that the healthcare industry is largely unprepared for the transition from legacy transaction formats to HIPAA-mandated formats. Second, it largely puts to rest any expectations for a regulatory or legislative extension to the October 16 deadline for compliance.

Grounding its enforcement policy on §1176(b) of the Social Security Act, CMS has formulated a flexible policy that is based on the facts and circumstances of each covered entity. Although the policy reaffirms the October 16 deadline and the legal duty to comply, CMS also stated that its enforcement process will be complaint-driven. The policy is designed to motivate health plans to build not only a track record of technical compliance but also one of outreach and testing with provider trading partners. If CMS receives a complaint, it will expect a showing of:

-Compliance, or
-Good faith efforts to comply, and
-A corrective action plan.

Good faith efforts will vary by setting. Indicators will include awareness outreach, testing and contingency planning. Health plans that have engaged vigorous outreach and testing will not be penalized if they operate legacy payment systems after October 16, 2003, that accept and process noncompliant claims. CMS will excuse these noncompliant systems as a form of contingency planning. Overall, pre-October 16
efforts will greatly outweigh the value of post-October 16 efforts. After October 16, 2003, CMS will expect noncompliant covered entities to submit corrective actions plans that remediate noncompliance in a time satisfactory to the Secretary.

**Long Quest for Universal Electronic Health Record Took a Few More Steps Forward**

On April 27, 2004, President Bush signed an executive order creating a National Health Information Technology Coordinator at the sub-cabinet level. The position will report directly to the Secretary of Health and Human Services. The National Coordinator will direct a plan to move the nation towards an interoperable, secure health information system that will reduce medical errors, improve healthcare quality, and produce greater value for healthcare expenditures. The executive order outlines a ten-year plan intended to:

1. Advance development and adoption of health information standards;
2. Address key technical, scientific, economic and other issues;
3. Evaluate and assess benefits and costs of interoperable health information technologies;
4. Address privacy and security related concerns with interoperable systems and recommend methods to insure authorization, authentication, and encryption;
5. Not rely on additional federal spending;
6. Include measurable outcome goals.

The plan will continue to build on ongoing initiatives to standardize health information and records. It will also attempt to leverage the purchasing power of federal healthcare programs to move standards closer to implementation.

I. **LEGISLATION**

**Congress Enacts Medicare Prescription Drug, Improvement and Modernization Act**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, P.L. 108-173 (Act), includes a broad array of provisions touching on health information technology. The Act will:

- Establish standards for electronic prescribing (e-scribing), including development of a safe harbor and Stark exception to enable physicians to receive e-scribing hardware, software and training used solely to receive and transmit information in the Medicare e-scribing program.
- Authorize Medicare Advantage Plans to promote e-scribing by participating physicians by offering differential payment to those who adhere to e-scribing standards.
- Establish matching (50/50) grants to enable physicians to acquire e-scribing hardware, software, etc.
- Create a Commission on Systemic Interoperability to develop a comprehensive strategy for adoption and implementation of healthcare information technology standards.
• Extending the duration and scope of the Telemedicine Demonstration Project begun under the Balanced Budget Act of 1997.
• Authorize a study and a report on skilled nursing facilities as originating sites of telehealth demonstrations.
• Impose upon Medicare contractors the obligation to develop and implement contractor-wide information security programs that will be subject to audit by independent auditors.

Require Medicare, and Medicare contractors, to establish Web sites to make relevant information available to Medicare beneficiaries via the Internet.


II. LITIGATION

U.S. Court in Arizona Dismisses Claim of Negligent Security Based on Lack of Evidence of Damages to Plaintiffs Whose Personal Information Was Stolen

A federal U.S. District Court in Phoenix, Arizona, dismissed most, but not all, of the complaint in a case involving the theft of a laptop computer containing personal information (e.g., names, social security numbers) on 500,000 military personnel from the offices of TriWest Healthcare Alliance Corp., a large contractor for the Department of Defense TRICARE program. Although the plaintiff class alleged negligent security, the court held that there was no showing of damages to the plaintiffs; and, absent damages, an allegation of negligence alone would not survive a motion to dismiss. The case is significant because in testimony on April 3, 2003, before the U.S. House of Representatives Subcommittee on Financial Institutions and Consumer Credit, TriWest testified at length about its mitigation efforts (e.g., contacting every beneficiary, contacting the media, establishing a web site, etc.) following discovery of the break-in. The ruling of the court suggests that TriWest’s mitigation efforts may have been sufficiently successful to blunt the initial theory of the lawsuit. An amended complaint remains an option.


The court’s dismissal suggests that the insurer’s effort to mitigate damages to individuals after their information was stolen may have successfully blunted the initial theory of the lawsuit.

U.S. Court in Florida Approves Settlements Between Health Insurers and Physicians

In the ongoing litigation between a class of roughly 700,000 physicians and most of the large commercial health insurers, the class physicians reached settlements approved by the court with CIGNA on September 4, 2003, and with AETNA on October 24, 2003. The settlements are significant with respect to health information technology and the law because both settlements obligate the defendant insurers to
make substantial investments in the information technology infrastructure and to use electronic information systems (e.g., e-mail, Web sites) to make their business processes more accessible to participating physicians. For example, in its settlement, CIGNA agrees to make substantial investments in Internet and clearinghouse connectivity to enable physicians to electronically pre-certify, submit claims, and check member eligibility. CIGNA also agrees to establish an e-mail address to enable class members to inquire about CIGNA’s claims administration policies and issues relating to coverage.

In re Managed Care Litig., No. 00-MD-1334 (S.D. Fla.).

The settlements are significant because they obligate insurers to invest in the information technology infrastructure and to use electronic information systems to make their processes more accessible to physicians.

**U.S. Court in Illinois Holds That HIPAA Privacy Standards Elevate State’s More Stringent Medical Privacy Act and Incorporate It into Federal Law**

The effect of HIPAA’s pre-emption provision was challenged in the maelstrom of abortion litigation surrounding challenges to the Partial Birth Abortion Ban Act of 2003. The case is significant because it will result in a better understanding of whether more stringent state laws have a role in privacy litigation in federal court, or whether the Privacy Standards alone control the use and disclosure of PHI in that forum. The U.S. Department of Justice argued that medical records subpoenaed by the Department could not be protected by more stringent Illinois law because the Supremacy Clause and Federal Rules of Evidence control what law applies in a federal forum. Nonparty hospitals objected to the government’s discovery of their medical records citing Illinois statutory and decisional law prohibiting disclosure of records even when identifying information had been redacted. The Court held that the Privacy Standards elevate Illinois’ more stringent Medical Privacy Act and incorporate it into federal law, making it applicable in a federal case. Clearly headed for appeal, the case has the potential to define for the federal courts what role will be played in federal court litigation by more stringent state law.


This case is significant because it will result in a better understanding of whether more stringent state laws have a role in privacy litigation in federal court, or whether the Privacy Standards alone control the use and disclosure of PHI in that forum.

**U.S. Court in Illinois Says It Has Authority to Order Plaintiffs to Sign HIPAA Authorizations**

The Privacy Standards again came into play in the context of a pharmacy malpractice suit. Defendants sought plaintiff’s prior mental health records, and the court ordered them disclosed pursuant to an authorization that plaintiff was ordered to sign. Plaintiff challenged the order and claimed that the court lacked authority to order plaintiff to sign an authorization. In what may be a first in the jurisprudence of HIPAA authorizations, the court held that “we clearly have the authority to require plaintiffs to
sign the authorizations.” Plaintiffs cannot bring a subject’s “mental health into issue and then refuse access by the defendants to relevant information.”


*This case is significant mainly because it asks and answers the question of whether a court can order a party to sign a HIPAA privacy authorization in litigation.*

**Texas Appeals Court Declines to Entirely Dismiss Pre-HIPAA Privacy Case Because Existence of Hospital Privacy Policies Did Not Prove Policies’ Enforcement**

One year after covered entity providers everywhere adopted numerous new policies, this case looks at liability founded on whether a Texas hospital adequately enforced similar policies adopted in accordance with state law. The facts involved a teenage girl, J.L., who was allegedly beaten by her boyfriend. Her mother took her to the local hospital, where she was x-rayed and treated for injuries. An employee of the hospital removed J.L.’s medical records from the hospital and showed them to the boyfriend. Sued for invasion of privacy and violation of Texas statutory law, the hospital sought to dismiss the action, arguing that it had adopted privacy policies and trained the employee on the policies and that in removing them, the employee clearly acted beyond the scope of employment. The hospital’s motion to dismiss was accompanied by a copy of its policies, an acknowledgment that the employee had received them, and a confidentiality statement signed by the employee. Notwithstanding this documentation, the Court held that the case could not be dismissed entirely because the existence of policies did not prove that they were actively enforced. Holding that the mere fact that the records had been removed from the hospital gave rise to a genuine issue as to whether the policies were adequately enforced, the court declined to dismiss the claim for negligent supervision of its wayward employee.


*In the policy and paper driven post-HIPAA world, this case nicely illustrates that enforcement of privacy policies will play a pivotal role in future privacy litigation.*

**Seventh Circuit Quashes Subpoena After Finding Records Sought Lacked Sufficient Probative Value to Outweigh Privacy Interest**

The Seventh Circuit quashed a subpoena for medical records on dilation and extractions performed at Northwestern Hospital in Chicago. The decision is important because the appeals court stepped back from the lower court’s ruling that the federal privacy regulations incorporated more stringent state protections and made them applicable in federal court on federal question cases. Instead, the appeals court disposed of the case on the narrower and more fact specific basis that the records sought lacked probative value sufficient to outweigh the loss of privacy that would accompany the disclosure of the records.

**Northwestern Mem’l Hosp. v. Ashcroft,** 362 F.3d 923 (7th Cir. 2004).
This case is important because the court quashed a subpoena on a fact-specific basis that the records sought lacked sufficient probative value to outweigh the loss of privacy.

U.S. Court in Pennsylvania Dismisses Challenge to HIPAA Privacy Standards
The U.S. Court for the Eastern District of Pennsylvania dismissed on summary judgment a challenge by a privacy advocacy group to the Privacy Standards. The case is significant in that it represents the last of the first generation of challenges to the Privacy Standards. Plaintiffs had focused particularly in this case on the repeal of the original rule requiring an individual’s consent. Dismissing the contention that the Secretary of Health and Human Services had exceeded his authority by eliminating the consent requirement, the court held that § 264 of HIPAA permitted the Secretary to balance privacy protections against efficiency of the healthcare system. 

This case emphasizes the Secretary’s authority under HIPAA to balance privacy protections against the efficiency of the healthcare system.

III. REGULATIONS

CMS Issues Final Regulations Mandating Electronic Claims Submission to Medicare
Implementing the Administrative Simplification Compliance Act, CMS published final regulations requiring all but the smallest Medicare providers and practitioners to submit electronic claims to Medicare. The impact of the rules will be threefold. First, the rules will reduce greatly Medicare’s volume of 139 million paper claims each year. Second, the required electronic submission will subject all but the smallest providers to compliance with HIPAA’s other rules on privacy and security. Third, CMS expects that once committed to electronic transactions for Medicare claims that providers will carry that commitment forward to all other types of transactions both with Medicare and non-governmental payors. Borrowing heavily from related HIPAA Administrative Simplification regulations, these regulations define a claim as one defined under the Standards for Electronic Transactions. 

FDA Adopts Final Rules Requiring Bar Codes on Prescription Drugs and FDA-Regulated OTC Drug Products
The Food and Drug Administration (FDA) adopted final rules that require all manufacturers, repackers, relabelers, and private label distributors of human prescription drugs or over-the-counter drug products regulated by the FDA to add a linear bar code to the label of their products. The bar code rules are a further step
towards a less error prone environment in healthcare and a demonstration of the belief that technology can play a major role to establish that environment.

The bar code must contain only the National Drug Code for the drug. The stated purpose of the bar code requirement is to reduce the number of medication errors. The FDA envisions the bar codes as an essential element of a wider effort that will involve hospitals installing bar code scanners that will feed bar code data into computer maintained databases of patient medication regimes. When a healthcare professional administers the drug in question, it will be scanned against the label bar code and a wristband with patient identifying bar code information.

The FDA was clear in stating that it did not regulate hospitals or their technological choices. For this reason, the FDA adopted the most prevalent and inexpensive form of technology (e.g., linear bar codes) rather than more sophisticated but less proven methods such as radio frequency identification chips. In addition, the FDA chose not to include lot and expiration data in the initial bar code content requirements. The FDA has stated that its objective is to establish for hospitals a reliable “technological floor” and monitor the need for other requirements. The bar code rules will take effect for newly approved drugs not later than sixty days following their approval and two years following the effective date of the rules for all existing drugs.


CMS Adopts Requirements for Unique Health Identifier for Healthcare Providers
The Secretary of Health and Human Services adopted final rules for a standard for unique health identifiers for healthcare providers. Adding yet another piece of the overall system of standards for administrative simplification, the national provider identifier (“NPI”) will consist of a ten-digit, numeric identifier with no embedded intelligence. The NPI must be used in all standard transactions. The compliance date for use of the NPI is May 23, 2007, for all but small health plans. NPIs will be issued to any healthcare provider, and sub-parts of providers. Providers seeking an NPI must apply to the National Provider System, which will conduct enumeration of providers for the government.

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I. ALTERNATIVE DISPUTE RESOLUTION

Colorado Supreme Court Says Notice Requirements for Arbitration Clauses in Medical Services Contracts Exempted from Federal Pre-Emption

Following her husband’s death, Karen Pacheco filed a wrongful death claim alleging negligence by her husband’s healthcare providers. The providers sought to submit the claim to binding arbitration pursuant to an arbitration provision contained in the contract between Pacheco’s husband and his health maintenance organization (HMO).

The Colorado Supreme Court held that, although the arbitration provision did extend to wrongful death actions filed by a member’s non-party spouse, Pacheco was not bound by the provision because it failed to comply with specific disclosures mandated by the Colorado Healthcare Availability Act (HCAA). The providers argued that the HCAA did not apply because it was pre-empted by the Federal Arbitration Act (FAA). The Colorado Supreme Court rejected this argument based on its finding that relevant HCAA provisions protect HMO policyholders and thus are statutes “regulating the business of insurance” under the meaning of the Federal McCarran-Ferguson Act, which permits such regulation by states. Allen v. Pacheco, 71 P.3d 375 (Colo. 2003).

This case is representative of litigation involving the McCarran-Ferguson Act and the Federal Arbitration Act, and is of particular significance in Colorado because a federal court in a prior Colorado case involving the same HMO reached the opposite conclusion with respect to this issue. See Morrison v. Colorado Permanente Med. Group, 983 F. Supp. 937 (D. Colo. 1997).

Florida Appeals Court Finds Nursing Home Arbitration Agreement Unenforceable Because It Deprived Resident of Statutory Rights

In a lawsuit based on allegedly inadequate nursing home care, the nursing home asserted a contractual right to arbitration signed by the patient’s husband upon admission. The Florida District Court of Appeal found the arbitration agreement substantively unconscionable to such a degree as to render it unenforceable. Although the appeals court noted certain procedural irregularities in the formation of the agreement, its finding of “egregious substantive unconscionability” was based on the fact that the arbitration agreement would have deprived the patient of certain rights under Florida statutes intended by the legislature to reduce elder abuse. Romano ex rel. Romano v. Manor Care, Inc., 861 So.2d 59 (Fla. Dist. Ct. App. 2003).

This case illustrates some of the issues involved in the use of arbitration agreements in the healthcare context. In addition to its specific application for Florida nursing
homes, when read together with Gainesville Healthcare Ctr., Inc. v. Weston (discussed below), it reinforces the need to carefully construct and implement such agreements.

Florida Appeals Court Says Nursing Home Admissions Contract Was Not Unconscionable

In a suit alleging negligence in the care of Isabella Brooks, defendant Gainesville Healthcare Center, Inc., moved to compel arbitration based on an admissions contract that contained an arbitration clause. The trial court found that Brooks' daughter, Barbara West, who signed the contract on Brooks' behalf, did not read the arbitration clause, although she was given an opportunity to do so and was not required to sign the contract immediately. The trial court further determined that no one had explained the arbitration clause before the contract was signed. For this reason, the trial court held that the admissions contract was unconscionable and denied the motion to compel arbitration.

The Florida District Court of Appeal, First District, reversed on the grounds that the circumstances of the case showed that West did have a meaningful choice. These circumstances include the trial court's finding that West had ample opportunity to review the contract and ask questions about it, and that the contract was not presented on a “take-it-or-leave-it” basis. The appeals court also found nothing to suggest the nursing home would not have deleted the arbitration provision had West so requested and that nothing that the nursing home had done had any impact on West’s failure to read the contract. Gainesville Healthcare Ctr., Inc. v. Weston, 857 So.2d 278 (Fla. Dist. Ct. App. 2003).

This case is significant because it illustrates procedural measures an organization can take to enhance the enforceability of an arbitration provision. This case focuses on procedural unconscionability, while Romano v. Manor Care, Inc., (discussed above) primarily deals with substantive unconscionability. Read together, these cases provide some insight into what may be required for the successful enforcement of an arbitration agreement in the healthcare setting.

Idaho High Court Holds Bad Faith Claim Was Subject to Arbitration

Peggy Lovey purchased an insurance policy from Regence BlueShield of Idaho. The policy contained a provision requiring arbitration of “any controversy or claim arising out of or relating to” the policy. After BlueShield denied Lovey’s benefits, she sued, claiming breach of contract and bad faith. BlueShield moved to dismiss the action or, in the alternative, to stay the proceedings pending arbitration, as required by the policy. The trial court denied the motion, and BlueShield appealed.

Among other issues, the Idaho Supreme Court considered whether the arbitration clause included within its scope the tort of bad faith. The high court noted that it had not previously construed the scope of an arbitration clause applying to “[a]ny controversy or claim arising out of or relating to” the contract, although a number of
other courts had. Based on a thorough analysis of the other decisions, the high court concluded that the bad faith claim fell within the arbitration provision because the claim could be established only by an analysis of the insurance policy. **Lovey v. Regence BlueShield**, 72 P.3d 877 (Idaho 2003).

*This case is significant because it is a case of first impression in Idaho and contains a detailed analysis of the applicability of arbitration clauses to bad faith claims in health insurance policies.*

II. FOOD AND DRUG LAW

**Federal Circuit Says Patent Extension Period Covers All Patent Claims for Active Ingredient**

Pfizer, Inc., owns a patent on a drug containing amlodipine as the active ingredient. Pfizer marketed the drug in a tablet form made with besylate salt. During the time Pfizer held the patent, Dr. Reddy’s Laboratories, Ltd. (Reddy), filed a new drug application to market amlodipine in a tablet form made with maleate salt. Pfizer sued Reddy for infringement of its patent. Reddy argued that it was not infringing Pfizer’s patent because the patent covered only besylate salt. The trial court agreed with Reddy and dismissed the complaint. Pfizer appealed.

On appeal, Reddy claimed its version of the drug used the maleate salt that Pfizer tested but did not use in its patent claims. Pfizer argued that the active ingredient is amlodipine and that merely changing the salt does not change the patented ingredient. The Federal Circuit determined that the Drug Price Competition and Patent Term Restoration Act (Hatch-Waxman Act) specifically addresses the loophole of merely changing the salt by defining a “drug product” as the active ingredient and excludes the salt or ester from the active ingredient. On this basis, the appeals court reversed the district court’s judgment, holding that a change of the salt did not change the infringement of the active ingredient amlodipine. **Pfizer, Inc. v. Dr. Reddy’s Labs., Ltd.,** 359 F.3d 1361 (Fed. Cir. 2004).

*A generic manufacturer cannot avoid patent infringement claims during a patent extension simply by changing the salt form of the patent holder’s drug.*

III. HOME HEALTHCARE

**Second Circuit Class Action Creates Notification Requirement for Terminating Home Health Services to Medicare Beneficiaries**

In a class action case, homebound Medicare beneficiaries sought declaratory and injunctive relief requiring the Secretary of Health and Human Services to compel home health agencies to provide greater procedural protections before reducing or terminating their services to Medicare beneficiaries. Vacating the lower court’s decision, the Second Circuit held that Medicare beneficiaries are entitled to written
notice before a home health agency terminates or reduces its services regardless of the reason, including lack of physician certification. The Second Circuit, however, agreed with the lower court that the Due Process Clause of the U.S. Constitution does not require the Secretary to conduct a pre-deprivation review of a home health agency’s adverse coverage determination. 

Healey v. Thompson, 361 F.3d 146 (2d Cir. 2004).

This case is significant because it creates additional notification requirements of home health agencies.

**IV. INDIVIDUAL/PATIENT RIGHTS**

**Connecticut Supreme Court Holds Plaintiff Raised Genuine Issue of Material Fact Whether Physician’s Statement During Fitness Examination Was Advice or Treatment**

While undergoing a physical examination to determine fitness for duty, a firefighter (plaintiff) was told by the testing physician that the results were fine and “they only found one irregular heartbeat.” Less than one month later, plaintiff suffered a heart attack. Shortly thereafter, plaintiff received written notice from the testing company of an abnormal EKG with a recommendation to seek further medical care. Plaintiff sued the testing service, claiming negligence. The appeals court upheld the trial court’s decision that the physician-patient relationship does not exist if the physician is retained solely to examine an employee on behalf of an employer, and therefore there is no duty upon which to base a medical malpractice claim. The court also found no exception for affirmative advice or treatment, i.e. the statement made to plaintiff about the EKG was neither advice nor treatment.

On appeal, the Connecticut Supreme Court held that there was a material issue of fact as to whether the physician’s statement about the EKG constituted advice or treatment and would result in duties owed to a patient by a physician. 


*Under Connecticut law, a physician-patient relationship does not exist if the physician is retained solely to examine an employee on behalf of an employer, and no malpractice action may be brought. However, where the provider affirmatively offers advice or treatment, it is up to the finder of fact to determine if a physician-patient relationship is created and resultant duties attach.*

**Massachusetts Appeals Court Holds Negligent Failure to Obtain Consent for Surgical Procedure Was Not Unfair Trade Practice**

Defendant physician performed a procedure to which plaintiff patient had not consented. Although plaintiff learned that the surgery performed was not the one she had consented to while in the recovery room on the day of surgery, plaintiff failed to file her complaint within the requisite statute of limitations, and the claim was
dismissed as untimely. Plaintiff also alleged that the physician’s failure to obtain her informed consent was deceptive and an unfair trade practice.

The Massachusetts Court of Appeals held that, while a physician may be negligent in failing to obtain informed consent, such actions do not constitute an unfair or deceptive trade practice.  

A claim for unfair or deceptive trade practices requires more than mere negligent failure to obtain informed consent. A negligent act standing by itself does not give rise to a claim under Mass. Gen. Law c. 93A. There must, in addition, be evidence that the negligence was or resulted in an unfair or deceptive act or practice.

**U.S. Court in Florida Says Informed Consent Is Not Needed for Use of Donated Tissue in Medical Research**

Families of children afflicted with a rare genetic disease donated blood and tissue samples to a physician researcher so that tests could be developed to determine carriers of the disease and for prenatal testing. Six years later, the research physician, now at another medical center, was successful in isolating the gene, and filed a patent application for the genetic sequence, which was granted. The plaintiff families filed suit for, inter alia, lack of informed consent.

Although the U.S. District Court for the Southern District of Florida acknowledged that, in certain circumstances, a medical researcher has a duty to obtain informed consent, because the plaintiffs were donors rather than test subjects, the Court declined to extend the informed consent duty for medical research to disclosure of possible financial interest.


*The duty to obtain informed consent does not extend to donors of genetic materials for research purposes, even when the researcher may develop an undisclosed financial interest in the research at some point in the future.*

**U.S. Supreme Court Allows Forced Medication to Render Mentally Ill Defendant Competent for Trial Only in Limited Circumstances**

The U.S. Supreme Court found the Constitution permits the government to administer drugs involuntarily to mentally ill defendants so that they may be competent to stand trial, but only in very limited circumstances. First, a court must find that important governmental interests are at stake. For example, the Government’s interest in bringing to trial an individual accused of a serious crime is important. In addition to its substantial interest in timely prosecution, the Government has a concomitant interest in assuring a defendant a fair trial. Second, the court must conclude that forced medication will significantly further those concomitant state interests. The court must find that medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with
the defendant’s ability to assist counsel in conducting a defense. Third, the court must conclude that involuntary medication is necessary to further those interests and find that alternative, less intrusive treatments are unlikely to achieve substantially the same results. Fourth, the court must conclude that administering the drugs is medically appropriate.  


The U.S. Supreme Court has delineated constitutional limitations on the government for involuntary administration of anti-psychotic medication to a defendant, which encompass a defendant’s Sixth Amendment rights. The Court emphasized that this framework should be applied only to determine competence to stand trial, not for other purposes.

V. MEDICAL MALPRACTICE

**New Causes of Action**

**Texas Supreme Court Refuses to Recognize Cause of Action for Parents’ Loss of Filial Consortium Due to Non-Fatal Injury**

Newborn Courtnie Williamson developed acidosis in a rural Texas hospital. Defendant, a consulting pediatrician, treated her, but Courtnie sustained permanent neurological injuries. In addition to compensation for negligence on behalf of Courtnie, her parents were awarded $75,000 for past loss of Courtnie’s consortium. A court of appeals affirmed.

The Texas Supreme Court reversed. In a case of first impression, the high court, while recognizing that loss of parental consortium is compensable, refused to extend such compensation to the reciprocal relationship. In the supreme court’s view, the major difference between the two is in the degree of dependency and remedies available. A dependent child without a parent is far more vulnerable and less able to remedy the situation than an adult faced with the loss of a child. Also, in the high court’s view, public policy dictates a limitation on “the consequential damages that flow from a single negligent act.”  


Though recognizing that serious injury to a child has emotional consequences for the parents, the court concluded that tort law cannot remedy every wrong.

**Vicarious Liability/Respondeat Superior**

**Georgia High Court Finds Hospital Not Vicariously Liable for Sexual Misconduct of Employee While Tending to Patient**

Following angioplasty at defendant Piedmont Hospital, plaintiff patient awoke to find a hospital employee about to perform fellatio on him. Though the employee was authorized to examine and cleanse patient’s groin wound, and in doing so, to
reposition his testicles, the Georgia Supreme Court concluded that there was no vicarious liability because the employee’s “acts were not taken in furtherance of [his] employer’s business and were outside the scope of employment.”

Three justices dissented, pointing out that the employee’s misconduct followed seamlessly from his authorized tasks and that a jury might properly find his misconduct essentially within the “prosecution and scope of employment.”

**Piedmont Hosp. v. Palladino, 580 S.E.2d 215 (Ga. 2003).**

*As the dissent stated, “the majority effectively establishes an absolute rule that . . . respondeat superior does not apply to cases involving sexual misconduct.”*

**U.S. Court in New Hampshire Finds Hospital Not Vicariously Liable for Actions of Anesthesia Staff in Claim Based upon Apparent Authority**

Plaintiff urologist underwent back surgery performed by defendant orthopedist at Concord Hospital (Hospital). Anesthesia was provided by an anesthesiologist and a certified registered nurse anesthetist (CRNA), both of who were independent contractors who did not hold themselves out as hospital employees. Prior to surgery, plaintiff signed a Hospital consent form that stated many of the staff physicians were not Hospital employees or agents. Following surgery, plaintiff suffered permanent vision loss and claimed, inter alia, that the Hospital was vicariously liable for the acts of the anesthesiologist and CRNA under a theory of apparent authority.

The U.S. District Court for the District of New Hampshire, in this diversity action, granted Concord’s motion for summary judgment on the vicarious liability claim, stating “there is no evidence that Concord Hospital performed any act or maintained any appearances which would lead a reasonable person to conclude that [Nichols and Sanborn] had the apparent authority to provide services at the behest of the Hospital.” The court found plaintiff’s sole reason for believing the anesthesiologist and CRNA to be Hospital agents was his “unsupported assumption.” The court also pointed out that evidence of apparent authority must flow from acts of the principal, not the agent.


*The court did not take notice of plaintiff’s presumed familiarity (as a surgeon) with physician-hospital contractual relationships, merely holding him to a “reasonably prudent person” standard.*

**Elements of Claims**

**Connecticut Appeals Court Requires More Than Statistics on Issue of Chance of Survival**

A sixteen-month-old baby died after admission to the hospital from an undiagnosed lymphocytic myocarditis. The parents (plaintiffs) sued the treating physician and hospital for medical malpractice. Plaintiffs’ expert testified that (1) it is difficult to determine which children will die from lymphocytic myocarditis and (2) he could not determine that, had the infant been transferred on admission to a tertiary care center
(which was one of the alleged acts of negligence), the infant would have survived. The trial court granted summary judgment in favor of defendants, holding that plaintiffs failed to establish causation.

The Connecticut Court of Appeals affirmed. Plaintiffs’ expert had based his testimony about the infant’s chances of survival solely on statistical evidence of all children with lymphocytic myocarditis who receive supportive care. The appeals court concluded this was a general opinion and could not support a finding of the infant’s actual chances of survival.


This case is significant in that the court required a specific individualized medical opinion with regard to a child’s probability of survival before a summary judgment could be entered on medical malpractice claim. Statistical evidence was not sufficient to raise an issue of fact with regard to the survivability of this particular child.

**New Jersey Appeals Court Refuses to Expand Duty of EMT to Require Extrication of Child from Pool**

Plaintiffs sued a hospital and its emergency medical technicians (EMTs) who were involved in providing emergency medical aid to a five-year-old child. Plaintiffs claimed that the EMTs were negligent in their rescue efforts by failing and refusing to enter a pool to search for the child, who was later found drowned. The facts demonstrated that the pool was not properly maintained; it had debris floating in it, and the water was black. The trial court dismissed the suit, finding that the EMTs had no legal duty to enter the pool.

The New Jersey Court of Appeals affirmed, noting that the EMTs were not trained nor required to be trained in water rescues. The appeals court concluded that extrication of the child from the pool was not a life support service required to be performed by EMTs. The EMTs, according to the appeals court, were under a duty to perform only medical services for which they were trained.


This court analyzed the scope of duty of an EMT and refused to broaden that scope to one alleged by plaintiff. Rather than base the opinion on immunity under New Jersey law, the court’s ruling in the instant case allows plaintiffs to argue what is or is not a “life support service” performed at the scene of an emergency for purposes of the immunity statute.

**Defenses**

**Massachusetts High Court Prohibits Striking Mandatory Affirmative Defense as Sanction for Loss of Records**

Plaintiff sued Brigham & Women’s Hospital, Inc. (Hospital), alleging the Hospital failed to diagnose and treat him for sepsis and meningitis after his birth, resulting in profound brain damage. The Hospital raised an affirmative defense of the statutory
damages cap available to charitable corporations. Subsequently, it was determined that the Hospital had lost plaintiff’s medical record, making it impossible for plaintiff to sustain his case. The trial court entered a default judgment of liability as a sanction under the discovery rules and also struck the damages cap defense as an additional sanction. The trial court reasoned that, although there was no evidence of willfullness or bad faith by the Hospital, striking the cap was fair because the Hospital and its doctors are insured by the same entity and without the records, plaintiff could not prove his case. Subsequently, the trial court entered a verdict against the hospital in excess of four million dollars. The appeals court affirmed the judgment in all respects.

The Massachusetts Supreme Judicial Court affirmed the default judgment on the issue of liability under the doctrine of spoliation, which provides that the party who negligently or intentionally loses or destroys evidence known to be relevant for an upcoming legal proceeding should be held accountable for the unfair prejudice to the other party. However, the high court vacated the judgment as to damages, holding that the judge lacked authority to strike the statutory cap as an additional sanction. The high court stated that the “plain text of the statute makes the cap mandatory and contains no language that would warrant its abrogation as a sanction for a violation of the sort that occurred here.”


Although loss of patient’s medical record may result in a directed verdict of liability under spoliation theory and/or other rules of court, a judge does not have authority to strike a statutory cap on damages as a sanction against a hospital’s violation of discovery rules.

Discovery, Evidentiary, and Trial Practice Issues

Massachusetts Appeals Court Finds Evidence of Professional Basketball Player’s Cocaine Habit, Employment Contract, and Insurance Policies Produced During Medical Malpractice Trial Was More Probative Than Prejudicial.

In a highly publicized case, Boston Celtic basketball player Reginald Lewis collapsed during a game and was subsequently treated by defendant physician. Lewis did not reveal to the physician that he was a cocaine user, resulting in an incorrect diagnosis and treatment plan that eventually led to Lewis’ untimely death in an unmonitored basketball game. When a jury returned a defense verdict against Lewis’ estate, his widow-executrix appealed the disclosure at trial of his cocaine use, an employment contract, and life insurance policies that would be vitiated by the disclosure of his habit.

The Massachusetts Court of Appeals ruled in favor of the defense’s argument that Lewis' nondisclosure led to his misdiagnosis and treatment. The appeals court also sided with the trial court’s view that disclosures of the policy and contract provisions were necessary to explain why plaintiff and her husband had concealed his cocaine use from his physicians.

This case is significant in that, even in a highly public trial, disclosure of sensitive information is permissible when the probative value outweighs the potential prejudice.

**Damage Elements**

**Michigan Appeals Court Says Statutory Charitable Immunity Cap on Non-Economic Damages Did Not Apply to Claims Brought Under Michigan’s Wrongful Death Act Predicated on Medical Malpractice**

Plaintiff’s estate sued a physician and hospital under Michigan’s Wrongful Death Act (WDA), claiming that their treatment of decedent was negligent and resulted in her death. The jury awarded plaintiff’s estate $10 million.

The Michigan Court of Appeals affirmed the trial court’s ruling that the WDA controlled and therefore the statutory damage cap on non-economic damages was inapplicable. The statutory damage cap statute includes a two-tiered cap, (the one for more severe injuries, e.g. paralysis, having a higher cap) and makes no reference to damages in the event of death. The appeals court reasoned that the two-tiered approach in the damage cap statute addresses an individual who has survived the malpractice and not situations in which the individual has died. Thus, the appeals court concluded that the legislature must have intended that the WDA would govern exclusively any wrongful death actions and did not intend the medical malpractice cap to apply.


This case is significant because it illustrates the importance of ensuring that legislation establishing damage caps for charitable organizations, such as hospitals, in medical malpractice also applies to actions brought under the state wrongful death statute.

**New Jersey Appeals Court Rules That Individual’s Social Security Contributions May Be Credited Against Social Security Disability Payment Collateral Source Deductions from Malpractice Award.**

Following arthroscopic knee surgery to repair a torn lateral meniscus in her right knee, plaintiff patient sustained permanent disabilities due to the negligence of Christ Hospital’s physical therapist in instructing plaintiff on the use of a Kinetron machine. A New Jersey trial court, deciding plaintiff’s damages in a subsequent medical malpractice action, deducted past and future Social Security disability payments. This was done under provisions of the state’s collateral source rule, which allows a defendant to deduct from the damages awarded to plaintiff the amount of benefits derived from insurance less the amount of premiums paid to the insurer.

In a case of first impression in any jurisdiction, the New Jersey Superior Court, Appellate Division, based on an analysis of legislative intent, ruled that the contributions plaintiff had routinely made to Social Security while employed were sufficiently similar to insurance premiums to qualify for the statute’s insurance premium payment credit.

New Jersey is now the first court to conclude that Social Security contributions are the equivalent of paying insurance premiums for purposes of a statutory credit under a state collateral source rule.

VI. PAYMENT ISSUES

Hospital Liens/Subrogation Issues

California Appeals Court Grants Patient’s Motion to Expunge Portion of Hospital Lien Based on Lien’s Failure to Conform to Statutory Standards

Plaintiff received medical treatment from a medical center operated by the county for injuries sustained in a fall in her apartment building. In connection with the county’s participation in the Medically Indigent Adult program, plaintiff signed a form during her hospitalization in which she agreed to reimburse the county for her medical treatment using the proceeds of any litigation or settlement related to her injuries. Following her treatment, plaintiff sued her landlord for negligence and settled with the landlord’s insurance company for $100,000. In response to notice that the county was asserting a hospital lien, the insurer issued two checks to plaintiff: one for less than half the policy proceeds made payable to plaintiff, and the other for $58,521.70 made payable jointly to plaintiff, her legal counsel and the county.

Based on California statutes, the California Court of Appeal held that the County was entitled to assert only a statutory hospital lien, and that the lien was further limited to an amount not to exceed 50% of the proceeds of the settlement.

Newton v. Clemons, 1 Cal.Rptr.3d 90 (Cal. 2003).

This case emphasizes the importance of following statutory mandates regarding hospital liens, rather than attempting to obtain a lien based on a contractual claim for reimbursement.

Indiana Supreme Court Holds Hospital Lien Was Properly Perfected When Sent to Patient’s First Attorney Even Though Plaintiff’s Subsequent Attorney Did Not Receive Notice of Lien

The Indiana Hospital Lien Act (Act) requires hospitals to place an attorney on notice that a lien has been filed for services rendered. Walter Phillips was injured in an automobile accident and treated at Parkview Hospital (Parkview). While hospitalized, Phillips hired an attorney to represent him in his personal injury action. The day before Parkview perfected its lien by filing a copy of the lien with the county recorder, Phillips dismissed his first attorney and hired attorney Kevin Tankersley. Tankersley did not receive a copy of the lien sent to the first attorney with Phillips’ file.

The Indiana Supreme Court held that, when Parkview sent a copy of the lien to the first attorney, it had met the requirements for perfecting a hospital lien under Indiana statute. The high court further held that the Act did not require Parkview to send
notices to subsequent legal representatives. In an aside, the supreme court noted that Tankersley should have expected a hospital lien to be on file at the county recorder’s office, and should have found the lien through his own due diligence. 


This case is important because it shows that, despite specific state statutory requirements regarding hospital liens, courts will stop short of holding hospitals to excessively harsh interpretations of those statutes.

Nebraska Appeals Court Upholds Decision Limiting Provider’s Lien to Unpaid Amounts Due Provider Under Managed Care Agreement

Debbie Lundin received medical treatment from Midwest Neurosurgery, P.C. (Provider), for injuries sustained in a car accident. At the time of treatment, Lundin signed a registration sheet providing for the coordination of benefits to fill the balance of the account in the event of multiple coverage. The contract between the Provider and Lundin’s managed care plan required the Provider to accept the negotiated fee schedule amounts as “payment in full” for the applicable services and to hold Lundin harmless for any amounts in excess of the fee schedule. The Provider filed a lien for the difference between the amount paid by the health plan and the amount representing the hospital’s usual and customary charges.

The Nebraska Court of Appeals held that the lien of a physician, nurse, hospital, or other healthcare provider under Nebraska statutes cannot exceed the amount the healthcare provider agreed to accept for the services rendered to a patient, even if the usual and customary charge for such services is greater than that sum.


This case is significant given the ongoing public concern regarding provider billing and payment issues.

VII. PRODUCTS LIABILITY

Illinois High Court Affirms Ruling That Defective Surgical Implant Was Not Subject to Implied Warranty of Merchantability Under UCC

The Illinois Supreme Court upheld the appellate court’s determination that a hospital’s sale of a medical device to a patient in conjunction with a surgical procedure did not constitute a sale of goods under the Uniform Commercial Code (UCC). Whether a hospital can be found liable to a plaintiff under a breach of implied warranty of merchantability under the UCC depends upon what the facts demonstrate was the predominant purpose of the transaction. In reaching its decision, the high court looked at the portion of the hospital charges for the product versus the total hospital charges for the procedure and engaged in an analysis to determine whether there was any useful purpose to plaintiff for the product without the surgical and/or medical treatment rendered. In finding that the cost of the procedure was substantially greater than the
product and that there was no value to plaintiff of possessing the product without the procedure, the supreme court held that the sale of the device was a sale of services, not goods, and therefore did not implicate the UCC. **Brandt v. Boston Scientific Corp.**, 792 N.E. 2d 296 (Ill. 2003).

The court considered the predominant nature of the hospital/patient transaction as a whole in its analysis and did not limit its consideration to costs, which, in some procedures using expensive implants, might weigh in favor of the product.

**Michigan Supreme Court Upholds Federal Law Limiting Drug Manufacturers’ and Sellers’ Liability on FDA Approved Drugs**

Plaintiffs, in two unrelated actions, sued Gate Pharmaceuticals and others for damages resulting from the use of certain prescription drugs. Defendant manufacturers raised, as an affirmative defense, the federal immunity statute that limits the liability of drug manufacturers and sellers for damages caused by drugs approved for safety and efficacy by the Food and Drug Administration (FDA) and labeled in compliance with FDA standards. One trial court found the federal statute to be an unconstitutional delegation of legislative power to the FDA to determine a cause of action. The second trial court upheld the federal immunity statute. The Michigan appeals court consolidated the cases and found that the federal immunity statute was an unconstitutional delegation of legislative authority because it placed the FDA in the position of final arbiter with respect to whether a particular drug formed the basis of a product liability action in Michigan.

The Michigan Supreme Court reversed, finding that the language of the federal act made it clear that Congress “has determined that a drug manufacturer or seller that has properly obtained FDA approval of a drug product has acted sufficiently prudently so that no tort liability may lie.” The high court held that the federal statute was a referral statute and that there is no improper delegation of power by the legislature in cases in which the agency making the determination, here the FDA, is doing so for purposes independent of the particular statute to which it makes reference. The FDA’s finding with respect to the safety and efficacy of a drug is merely a measuring device, which measure Congress has deemed an appropriate standard of care. Therefore, there was no delegation of power to the FDA under the federal drug manufacturers’ immunity statute. **Taylor v. Smithkline Beecham Corp.**, 658 N.W. 2d 127 (Mich. 2003).

The narrow analysis upholding the constitutionality of the statute as a proper referral statute, could find further challenge in other venues. Whether federal pre-emption would provide a stronger rationale for upholding the immunity statute is only casually referred to in the dissent.
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I. ERISA ACTIONS

U.S. Court in Florida Holds That Plan’s Anti-Assignment Clause Barred Medical Provider from Pursuing Claims Against Plan Administrator Under ERISA

Motorola, Inc., an ERISA plan sponsor, moved for summary judgment, which a federal court granted based on the medical provider’s lack of standing to pursue claims for benefits that were assigned to him by the member due to the anti-assignment clause in the plan. The anti-assignment clause provided that the rights of any participant under the plan could “not be voluntarily or involuntarily assigned or alienated.” The medical provider argued the anti-assignment clause was intended to prevent beneficiaries from transferring rights to receive actual medical services to another individual not covered by the plan, or from diverting benefit funds to an unrelated debt. The medical provider also argued the plan may make direct payments to healthcare providers for services rendered to plan participants and beneficiaries, and therefore the clause does not prohibit assignments of a cause of action to a provider.

The U.S. District Court for the Southern District of Florida held that a medical provider could not pursue assigned claims against a plan administrator under ERISA, relying on the plan’s enforceable anti-assignment clause that prohibited assignment of a plan beneficiary’s cause of action to third-party medical providers. Although the court reasoned that the only parties with ERISA standing are those listed in the statute’s civil enforcement provision, which does not include medical providers, the court noted that a medical provider might acquire standing through an assignment of benefits when a plan does not prohibit assignments of benefits.


Anti-assignment clause prohibits HMO plan member from assigning benefits to medical provider for collection from an ERISA plan

Eighth Circuit Allows for Equitable Rescission of ERISA Plan Coverage When Such Coverage Is Obtained Through Material Misrepresentations or Omissions By Insured

Plaintiff completed an enrollment form to obtain health insurance through his employer’s health plan, which was administered by Arkansas Blue Cross and Blue Shield (BCBS). Plaintiff answered “No” to the question of whether he had a known indication of, or been treated for, emphysema and chronic obstructive pulmonary disease (COPD). Months after he completed the enrollment form, plaintiff was diagnosed with cancer, COPD, and emphysema. After an investigation, BCBS determined that, prior to completing the enrollment form, plaintiff had been treated several times for chest congestion. Thus, based in part on plaintiff’s diagnosis and prior treatment, BCBS rescinded his coverage because there were material misrepresentations made in his enrollment form.
Plaintiff sued BCBS, alleging it was an abuse of discretion to rescind his coverage. After an appeal, the Eighth Circuit joined other circuits that have adopted federal common law allowing equitable rescission of coverage provided under an ERISA plan when that coverage is obtained through material misrepresentations or omissions by an insured. In addition, the court ruled the plaintiff did not have to intend to make the misrepresentations or omissions, as long as it is revealed in the medical records and related documentation.

Shipley v. Arkansas Blue Cross and Blue Shield, 333 F.3d 898 (8th Cir. 2003).

*Federal common law allows an ERISA plan to rescind coverage obtained through misrepresentations or omission, even if the plaintiff did not intend to misrepresent or omit medical information.*

**Third Circuit Says HMO Had No Fiduciary Duty to Disclose Physician Compensation Scheme to Subscribers**

The Third Circuit held that a health maintenance organization (HMO) has no fiduciary duty under ERISA to disclose its physician compensation scheme to its subscribers. The appeals court reasoned that ERISA does not impose a duty on HMOs to disclose its physician incentives or compensation scheme absent a subscriber’s request for that information.

The appeals court also found that plaintiff had not alleged that she had been personally affected by the existence of physician incentives, or that she had received defective or substandard medical care because of physician incentives. Thus, the appeals court found the HMO had no duty to disclose that information and would only be under such a duty when it is placed on notice a subscriber requires that information to make a healthcare decision.


*A HMO has no fiduciary duty under ERISA to disclose its physician compensation scheme to subscribers.*

**Eleventh Circuit Holds That ERISA Did Not Pre-Empt HMO Member’s Medical Malpractice Claim in Case in Which HMO Nurse Had Made Mixed Eligibility and Treatment Decision**

Plaintiff sought medical treatment for a cat bite in an emergency room at a local hospital. A hand specialist, who was approved by plaintiff’s HMO, treated plaintiff for an infection and subsequently released him from the emergency room. The infection did not improve, and plaintiff’s primary care physician and the hand specialist later agreed that he needed inpatient care and intravenous antibiotics. After he was admitted to the hospital, a nurse employed by the HMO denied coverage for the inpatient stay, claiming it was unnecessary because outpatient care would be appropriate. Thus, the nurse arranged for plaintiff’s discharge from the hospital. The infection worsened, eventually causing plaintiff to lose a finger. Plaintiff filed suit in state court, alleging the HMO provided him negligent care and treatment. The case
was removed to federal court based on federal question jurisdiction under ERISA. The federal court dismissed the medical malpractice claim, finding it was pre-empted by ERISA’s civil enforcement scheme.

The Eleventh Circuit, however, disagreed, based on its interpretation of Pegram v. Herdrich, 530 U.S. 211 (2000). First, the appeals court determined that the HMO’s nurse made a mixed eligibility and treatment decision by denying inpatient hospital care and authorizing outpatient care. See Cicio v. Does, 321 F.3d 83 (2d Cir. 2003). Second, the court found plaintiff’s medical malpractice claim was not a claim for coverage benefits under an ERISA plan and thus was not pre-empted by ERISA’s civil enforcement scheme. Based on this determination, the appeals court found that removal jurisdiction was inappropriate, and remanded the case back to state court. Land v. CIGNA Healthcare, 339 F.3d 1286 (11th Cir. 2003).

This decision is the most notable decision because it shows the continued deterioration of ERISA pre-emption and the increasing risk of substantial liability for ERISA plans.

Seventh Circuit Says ERISA Pre-Empts Illinois Common Fund Doctrine
The Seventh Circuit held that, in relation to exercising its subrogation rights, an ERISA plan is not required to pay a proportionate share of attorneys’ fees incurred by a plan participant in her personal injury lawsuit under Illinois’ common fund doctrine. The court found the common fund doctrine is pre-empted by ERISA because (1) it conflicted with the terms of the ERISA plan at issue and (2) ERISA requires that plans be administered in accordance with plan documents. The appeals court also found that ERISA provided the health plan a cause of action to recover medical expenses from one of its participants who was already paid. The court reasoned that, in this instance, the participant held her settlement proceeds in a reserve, which made the funds sought by the plan under its subrogation clause identifiable and allowed it to seek appropriate equitable relief under ERISA’s civil enforcement scheme. Administrative Committee of the Wal-Mart Stores Inc. Assocs.’ Health and Welfare Plan v. Varco, 338 F.3d 680 (7th Cir. 2003).

ERISA plans are not required to pay proportionate share of attorneys’ fees to a participant related to her personal injury lawsuit

U.S. Court in Texas Finds That ERISA Does Not Pre-Empt Hospital’s State Law Claim Alleging Negligent Representation by Health Plan
A federal district court in Texas found that ERISA did not pre-empt a hospital’s state law claim alleging that a health plan negligently represented it would cover medical treatment provided to one of its members. The court found factual issues regarding the notice provided to the hospital by a pre-recorded telephone message, which stated that pre-authorization is not a guarantee of payment. The insurer later denied the coverage it pre-authorized, claiming that, because the plan participant was under the influence of marijuana at the time he was injured, he was subject to a clause in the plan excluding coverage for accidents caused by drugs and alcohol. Despite the
court’s holding that ERISA did not pre-empt the hospital’s claim, the court found the hospital lacked third-party standing to pursue its claim under the contract. **Methodist Hosps. v. Wal-Mart Stores, Inc.,** Case No. 3:02-CV-0656-D, 2003 WL 2126675 (N.D. Tex. May 30, 2003).

ERISA does not pre-empt provider’s claim that a plan negligently represented it would provide medical coverage.

**U.S. Court in Pennsylvania Holds Insurer’s Subrogation Claims Are Not in Violation of Pennsylvania’s Motor Vehicular Financial Responsibility Law and Are Pre-Empted by ERISA**

Plaintiff, on behalf of himself and other similarly situated class members who suffered personal injuries in motor vehicular accidents, sued Aetna U.S. Healthcare in state trial court, alleging that the insurer violated the Pennsylvania Motor Vehicle Financial Responsibility Law (MVFRFL) when it sought subrogation against plaintiff’s tort recovery. In addition to seeking damages under § 1720 of the MVFRFL, plaintiff asserted claims of breach of contract, unjust enrichment, and bad faith insurance practice under 42 Pa. Cons. Stat. Ann. § 8371, and requested declaratory and injunctive relief. Aetna asserted liens against the tort recoveries of plaintiff and other class members for the medical benefits provided pursuant to the indemnification and subrogation clauses in its healthcare agreements. Aetna removed the action to federal court based on pre-emption under ERISA. Plaintiff argued that the claims were directly related to the amount of the tort recovery and were only distantly related to the healthcare benefits previously granted by Aetna.

The U.S. District Court for the Eastern District of Pennsylvania indicated there is an inextricable connection between Aetna’s lien and the amount due under plaintiff’s healthcare agreement. As the claims fell within § 502(a)(1)(B) of ERISA, the court found them completely pre-empted and thus denied plaintiff’s motion to remand the matter to state court. **Wirth v. Aetna U.S. HealthCare,** No. 03-5406, 2004 WL 253525 (E.D. Pa. Feb. 10, 2004).

District court rules that ERISA pre-empt a subscriber’s claim that state motor vehicle state prohibits a plan’s assertion of liens on recoveries from third party tortfeasors.

**U.S. Court in Texas Says ERISA Did Not Pre-Empt Medical Center’s Lawsuit Asserting Breach of Contract and Violation of Texas Insurance Code**

Baylor University Medical Center (Baylor) sued Arkansas Blue Cross Blue Shield (ABCBS) for breach of contract and late payment of claims under the Texas Insurance Code, seeking to recover the costs of providing medical services to an insured of ABCBS. ABCBS removed the action to federal court based on pre-emption by the Employee Retirement Income Security Act of 1974 (ERISA). Baylor moved to remand the case back to state court.
The U.S. Court for the Northern District of Texas granted Baylor’s motion, holding that certain state law causes of action are not pre-empted by ERISA when brought by independent, third party healthcare providers and cited several cases. In so holding, the court relied on the two-pronged test set forth in *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F. 2d.236 (5th Cir. 1990). The court noted (1) that Baylor’s contract claims were neither dependent upon nor derived from the ACBCBS insured’s rights to recover benefits under an ERISA plan and (2) that the contract claims did not directly affect or modify the relationship between ABCBS and its plan participants or beneficiaries. The court also strongly indicated that it would not, in the name of ERISA, insulate an insurer from liability against a third-party healthcare provider seeking to enforce its rights under a state statute that requires prompt payment of claims.


*District court lacked subject matter jurisdiction over a medical center’s claims of breach of contract and violation of the state insurance code.*

**Ninth Circuit Says State Breach of Contract Claim to Enforce Plan’s Reimbursement Provision Was Not Pre-Empted by ERISA**

When the insureds were injured in a car accident and recovered from the liable driver, their health plan sought to enforce both the plan provision requiring reimbursement from third-party recoveries and a separate agreement that the insureds had signed directing their attorney to reimburse the plan from their personal injury case proceeds. The insureds refused, and the plan sued in state court, alleging breach of contract. After the plan’s state court breach of contract suit was removed and then dismissed on the basis of ERISA pre-emption, the plan sued in federal court, seeking the equitable remedy of specific performance under ERISA. The court dismissed this action as well, finding that the plan was in fact seeking a legal remedy not available under ERISA, in accordance with *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

However, the Ninth Circuit concluded that the state-law breach of contract claim was not pre-empted by ERISA. The contract claim, the appeals court held, did not have “a connection with or reference to” an ERISA plan because it did not require interpretation of an ERISA plan and did not involve any distribution of benefits under that plan. The appeals court further determined that the contract claim was not removable because it did not fall within the scope of ERISA’s equitable enforcement provisions. Rather, the plan sought ordinary monetary damages under state contract law.

*Providence Health Plan v. McDowell*, 361 F.3d 1243 (9th Cir. 2004).
U.S. Court in New Jersey Says Pharmacy Benefit Manager Is Not ERISA Fiduciary
A pharmacy benefit manager (PBM) is not an ERISA fiduciary and thus ERISA did not pre-empt an insurer’s claim against it for breach of fiduciary duty under state law. A health plan sued the PBM, claiming that it breached its contracts by failing to observe cost-cutting measures, such as substitution of generic drugs, in providing pharmaceuticals to the plan’s members. The U.S. Court for the District of New Jersey noted that there is “substantial doubt” that the PBM was a fiduciary under ERISA at all, but also noted that, particularly in the case before it, which was based on allegations relating to the manager’s performance of ministerial tasks under the parties’ contract, it clearly was not acting in an ERISA fiduciary capacity. Group Hospitalization and Med. Servs. v. Merck-Medco Managed Care LLP, 295 F. Supp. 2d 457 (D.N.J. 2003).

The federal court in New Jersey declined to treat a PBM as a fiduciary for purposes of ERISA.

U.S. Court in Tennessee Finds Claims Against Drug Manufacturer Were Not Connected to ERISA Plan and Thus Were Not Pre-Empted
A Tennessee federal court rejected the argument by the manufacturer of the controversial drug OxyContin that a suit under state monopolization and consumer protection laws was pre-empted by ERISA. The consumer case arose because of the manufacturer’s earlier patent infringement suit against the manufacturer of a generic substitute. The court in the patent case ruled that the generic drug manufacturer had infringed the patent, but that the patent was unenforceable because of the patent holder’s inequitable conduct before the Patent & Trademark Office by intentionally misrepresenting information about OxyContin.

Thereafter, the consumer class sued on antitrust and consumer protection theories. In remanding the matter to state court, the U.S. District Court for the Western District of Tennessee observed that the complaint nowhere mentioned an ERISA plan or any connection to an ERISA plan. Moreover, the court observed that, even had the matter involved an ERISA plan, it still would not be pre-empted, because the claims were not related to any plaintiffs’ benefits or rights under such a plan, but rather were based on state laws of general applicability. Coker v. Purdue Pharm. Co., 2004 WL 870661 (W.D. Tenn. Apr. 23, 2004).

This case demonstrates a federal court’s unwillingness to subject antitrust and consumer protection theories to ERISA pre-emption.

Sixth Circuit Rules That Agent of ERISA Fiduciary Lacks Standing to Sue Under ERISA
The agent of ERISA employer-fiduciaries lacks standing to sue under ERISA in its own name as agent, the Sixth Circuit recently held. COB Clearinghouse acted as agent for various employers under contracts to determine whether the employers’ plans were secondarily liable for benefits and to pursue those parties that might be
primarily liable. COB then sued a group of insurers under ERISA, as agent for the employers, to recover benefits owed. The Sixth Circuit affirmed the district court’s dismissal of the action based on lack of standing. The appeals court rejected COB’s argument that it could bring the suit on behalf of the fiduciaries for which it acted as agent, because ERISA specifically limits standing to participants, beneficiaries, and fiduciaries, and “courts narrowly construe ERISA to permit only the parties specifically enumerated to bring suit.”


The Sixth Circuit’s opinion is an example of a federal court’s unwillingness to extend standing under ERISA to parties other than those specifically listed in the statute.

U.S. Bankruptcy Court in New Jersey Says Medical Provider to Whom HMO Subscribers Assigned Benefits Has Standing to Sue HMO Under ERISA

A bankrupt medical provider, Lymecare, brought suit against an HMO, seeking reimbursement for claims assigned by subscribers to Lymecare while it was a part of the HMO’s provider network. The HMO refused to pay, arguing the claims were not covered because Lymecare had failed to observe the HMO’s policies regarding treatment for Lyme Disease. The HMO challenged Lymecare’s standing under ERISA, as it did not fall within an enumerated category of those entitled to bring suit.

Noting that the Third Circuit had never ruled on the particular issue of the ERISA standing of an assignee of benefits, the U.S. Bankruptcy Court for the District of New Jersey found “the overwhelming weight of authority among other circuits” supported granting standing to Lymecare. Therefore, Lymecare’s state-law claims were preempted. With respect to the provider’s reimbursement claims arising from non-ERISA governmental plans, the bankruptcy court dismissed the provider’s claims for failure to exhaust its administrative appeals.


The Bankruptcy Court in New Jersey joined with several federal circuits in granting ERISA standing to benefits assignees.

Fifth Circuit Says Health Plan Was Not Entitled to Reimbursement from Settlement Funds That Tortfeasor Offered to Subscriber, but That Subscriber Rejected

The Fifth Circuit rejected a health plan’s attempt to enforce its medical reimbursement clause when its insured rejected a tendered settlement of her personal injury action. The subscriber was injured in a car accident, and the plan paid for her medical treatment. However, when the responsible driver’s insurance company tendered the subscriber a policy-limits check, she refused the settlement and returned the check. Nonetheless, the plan sought to enforce a provision requiring her to reimburse the medical expenses from the personal injury proceeds.
The court relied on the U.S. Supreme Court’s Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), decision, which had contemplated that enforcement of reimbursement provisions under ERISA must seek specifically identifiable funds for a constructive trust theory to apply. In the instant case, where the offered funds had been returned to the payer, there was no fund to which the trust could attach. The fact that the offered check was a negotiable instrument was irrelevant, because the insured would not have been entitled to accept the check without releasing her tort claims, which she had not done.


This case is important because it draws upon the recent Great-West Supreme Court decision and shows that a constructive trust will not be found if an insured did not actually collect funds that were offered as settlement.

II. MANAGED CARE

Texas Appeals Court Says BCBS Was Not Common Law Charitable Corporation Prior to Merger

The Texas Court of Appeals for the Third District in Austin held that Blue Cross and Blue Shield of Texas, Inc. (BCBS), was not a common-law charitable corporation prior its 1998 merger with Health Care Service Corporation. The court reasoned that the evidence showed that BCBS had never had a public charitable purpose and that all revenues generated were used to benefit policyholders or BCBS’s own corporate purposes.

The ruling means that Health Care Service Corp., a not-for-profit mutual insurer that merged with BCBS, does not have to pay $350 million plus interest in compensation to charitable trusts or foundations previously selected by the Texas attorney general. The amount was stipulated to in a settlement agreement allowing the merger between the two to proceed, which was to be paid only if BCBS was found to be a common-law charitable corporation by a court in Texas.


Blue Cross is not a common-law charitable corporation in Texas, according to a Texas court of appeals.

Eleventh Circuit Remands for Arbitration Physician’s RICO Claims Against Managed Care Industry

Plaintiff physicians alleged that defendant HMOs adopted and utilized reimbursement policies and procedures that violated both the Racketeer Influenced and Corrupt Organizations Act (RICO) and state prompt pay laws, and used their market power to force the physicians to accept harmful managed care practices. On April 7, 2003, the U.S. Supreme Court ruled that the insurance contracts requiring arbitration are enforceable even in the context of RICO claims. PacifiCare Health Sys., Inc. v. Book,
123 S. Ct. 1531 (2003). Physicians argued the arbitration provisions were unenforceable because they would not allow treble damages that are available under RICO. The Supreme Court disagreed, reasoning the arbitrator should decide in the first instance whether some or all of the contracts allow treble damages under RICO. The High Court found it would be premature for it to determine dispute between the parties when they already agreed to authorize an arbitrator to resolve any disputes regarding limits on statutory or contractual remedies. In accordance with the Supreme Court’s decision, the Eleventh Circuit remanded the RICO claims to the federal district court with instructions to follow the Supreme Court’s decision.

In addition to the developments with respect to arbitration of some of the physician tract claims, on May 29, 2003, the trial court judge gave preliminary approval of a settlement agreement of about $470 million to resolve claims brought by approximately 700,000 physicians against Aetna Inc. (In re Managed Care Litigation, MDL No. 1334 (S.D. Fla., prelim. approval granted May 29, 2003). The settlement would settle claims raised in the national class action along with other actions against Aetna in state courts.

In re Humana Inc. Managed Care Litigation, 333 F.3d 1247 (11th Cir. 2003).

MDL RICO claims remanded and physician settlement with AETNA obtains preliminary approval.

Ohio Appeals Court Affirms Judgment That Physicians’ Antitrust Claims Against HMOs Are Not Subject to Arbitration Provisions in Provider Agreements

The Court of Appeals of Ohio affirmed the lower court’s judgment that the dispute of conspiracy to engage in price-fixing did not arise out of or relate to the provider agreements between the parties. The court concluded the parties had not agreed to arbitrate claims that were independent of any breach of contract.

All parties to the action agreed there was a valid arbitration clause in each of the HMOs’ contracts with the plaintiff physicians. The question was whether “any disputes arising out of or relating to the provider agreement or business relationship” had to be resolved through arbitration, mediation, or some form of alternative dispute resolution. In determining this, the appeals court assessed whether the action could be maintained without reference to the provider agreement or business relationship at issue. If it could, the action was likely outside the scope of the arbitration agreement. The court found that the allegations that the HMOs, which controlled a majority of the healthcare market in the region, colluded to fix reimbursements to medical practitioners arose out of actions that occurred prior to the existence of the underlining provider agreements or business relationships between the doctors and the HMOs. As the cause of action could be maintained without reference to the provider agreements, the court affirmed the lower court judgment that the antitrust claims are not subject to the arbitration provisions in the provider agreements. Humana originally field a notice of appeal and an appellate brief in connection with this case, but Humana voluntarily dismissed its appeal.

Physicians’ antitrust claims are not subject to the arbitration provision in the provider agreement.

Humana Settlement of $100 Million with Cincinnati Area Physicians Receives Joint Approval from Judges
Cincinnati area physicians brought a class action alleging a conspiracy to hold down medical reimbursement rates against Humana, Aetna Health Inc., United Healthcare of Ohio Inc., and Anthem Blue Cross Blue Shield, which together control 92% of the Cincinnati area healthcare market. Plaintiffs alleged that the insurers have exploited their “significant HMO market share” and colluded to reduce reimbursement rates. Humana settled with plaintiffs, denying wrongdoing, for an estimated $270 million for 2003, which will be increased by $20 million in 2004, $35 million in 2005, and $45 million in 2006. From 2007 to 2010, a three-person oversight committee will monitor the fairness of Humana’s reimbursement rates by examining random cases.


Humana settles alleged antitrust action with Cincinnati physicians.

CIGNA Settles Managed Care Class Action
Cigna settled a class action lawsuit that had named Aetna, Cigna, United Healthcare, Coventry, WellPoint, Humana, PacifiCare, and Anthem Blue Shield as defendants and co-conspirators who allegedly violated contracts and defrauded physicians in violation of the federal Racketeer Influence Corrupt Organization Act (RICO). Cigna had proposed a settlement in September 2003 and is now the second defendant to reach settlement with the plaintiff physicians.

The U.S. District Court for the Southern District of Florida found the settlement fair and in the best interest of the class. The requirements include: increased automated adjudication of claims, Internet disclosures and additional information on Cigna’s Web site, policies and procedures for appealing claim denials, posting of medical necessity clinical guidelines and external review details, identification of drug formularies and databases of reasonable and customary charges, and disclosure of eligibility and benefits online. Cigna is to establish a physician advisory committee and a foundation, and to make a deposit of $15 million to the foundation. Cigna is to implement an independent external billing dispute review process for resolving disputes with class members concerning the application of Cigna’s HealthCare’s coding and payment rules and methodologies. An appeals process with respect to determination that a healthcare service or supply is not medically necessary or is of an experimental nature or investigational is to be established. Within ninety days of the final approval of the settlement, Cigna is to create a settlement fund of $30 million and a claims distribution fund of $2,500,000. If less than $40 million is paid under the claims distribution fund, Cigna is to pay the foundation the difference.

Cigna is the second defendant to settle the class action In RE Managed Care Litigation.

Texas Jury Awards Multi-Million-Dollar Damages Under State Law That Allows Lawsuits Against Health Plans for Benefit Decisions
A Texas jury awarded $3 million in compensatory damages and $10 million in exemplary damages (the latter vacated on appeal) against an HMO in the first substantial jury award under a 1997 Texas law allowing members to sue health plans for damages relating to benefit determinations.

The decedent subscriber had been hospitalized and then placed in a skilled nursing facility (SNF) for a number of conditions, including emphysema, for which he required supplemental oxygen. Upon his discharge from the SNF and his transport home to be cared for by his family, a series of confusions and mix-ups on the part of plan medical personnel resulted in the supplemental oxygen not being provided. Decedent was re-hospitalized and died shortly thereafter. His family sued CIGNA for negligent “healthcare treatment decisions.” The Texas Court of Appeals affirmed the compensatory award, but vacated the exemplary damages due to lack of clear and convincing evidence of the requisite willfulness or gross negligence on the part of the plan.


This case is significant because it is the first substantial jury award under a 1997 Texas law that allows health plan members to sue their plans for damages relating to negligent benefit determinations.

California Appeals Court Rules That Health Plan Was Not Required to Pay Provider Fees Where Payment Obligation was Delegated to Now-Insolvent IPA
Plaintiff, a healthcare provider, sued defendant, a healthcare service plan, claiming that defendant was obligated under California’s Knox-Keene Act, which requires healthcare service plans to pay providers for emergency care rendered to its enrollees, to pay plaintiff’s fees when the intermediary independent practice association (IPA) became insolvent. Defendant had delegated this payment obligation to the IPA, as authorized by the Knox-Keene Act. Plaintiff argued that defendant could not delegate that obligation, relying on a general statute enacted in 1872, which provides the general rule regarding delegation of legal obligations.

The California Court of Appeal rejected the argument that the statutory section would take precedence over the more specific provision of the Knox-Keene Act itself, which the court found expressly contemplated that a healthcare service plan could delegate its emergency care payment obligations (and had done so in that case, to the bankrupt IPA). The appeals court did note that the plan might have been liable for payment of these services had its delegation been made negligently.

This case emphasizes that a specific provision will trump a general statutory rule regarding the delegation of legal obligations.

III. INSURANCE

Tenth Circuit Says HMO’s Calculation of Copayments Was Reasonable, Even if HMO Had Negotiated Lower Prices for Services
Members of a Utah-based HMO filed a class action alleging that the HMO improperly calculated their copayments without taking into account negotiated fees accepted by the HMO’s providers. The Tenth Circuit dismissed the case, finding the HMO’s calculation of copayments was reasonable when done as a percentage of the providers’ full-billed charges, even if the HMO had negotiated lower prices for those services.

The HMO provided coverage under ERISA, and the schedule of benefits provided to all members clearly stated they would make copayments that were a percentage of their eligible expenses. The HMO, however, paid its participating providers a negotiated amount and, rather than using that amount to calculate copayments, the HMO used the providers’ full billed charges to calculate the copayment amounts. The court found the copayments would range from 10% to 20% of eligible expenses. Thus, based on the overall structure of the HMO and information provided to members when enrolling, the appeals court found the HMO’s plan design is to shift a portion of the actual cost for healthcare services to its members, which under the circumstances, was reasonable.

Lefler v. United Healthcare, No. 01-4428 (10th Cir. Aug. 14, 2004).

This decision found that the calculation of copayments as a percentage of providers’ billed charges was reasonable, even though the HMO had negotiated lower prices for provider services.

Medicare Reform Will Mean Restructuring of Program
With the enactment of reform measures to the Medicare program, sweeping changes are envisioned for the entitlement program. The legislation marks the end of a six-year effort to redefine the Medicare program. One primary aspect of the package is a new prescription drug benefit, which is set to be available in 2006, with an interim plan to allow for provision of a discount card drug program for seniors. Additionally, starting in 2010, the law envisions competitive forces to be introduced on a limited scale whereby private health plans would compete with Medicare. There are increases in federal payments to doctors and hospitals, and a new provision begins to subsidize employers that provide health benefits for retirees. The new legislation also creates tax benefits for people who open special savings accounts for medical expenses and allows for steps to make low-cost generic medicine more readily available.
CMS Emphasizes PPOs for Medicare Reform
While Congress considered a Medicare reform and prescription drug benefit package, CMS announced its intention to implement any new legislation by emphasizing preferred provider organizations (PPOs). The focus of this effort is to develop regions throughout the country to ensure that Medicare beneficiaries have access to a private coordinated care plan. CMS’ actions are being influenced by the recently enacted Medicare reform legislation.

The new legislation provides for sweeping changes to Medicare by establishing regional PPOs. The goal is to ensure that rural areas, as well as more financially advantageous areas, have access to private coordinated care plans. CMS explained that it is undertaking modeling studies using factors such as metropolitan statistical areas and referral practices to ascertain the availability to beneficiaries of a PPO or HMO. CMS is using data gathered from its PPO demonstration program, which began in January 2003.


This agency action is significant because it gives insight into how CMS intends to implement new reform measures to the Medicare program Congress has enacted for a prescription drug program.

Third Circuit Finds State Negligence Action Against AETNA Completely Pre-Empted Under ERISA
Plaintiff was a participant in an employee health benefit plan governed by ERISA and administered by Aetna. Plaintiff’s physician prescribed a specially designed tracheostomy tube after the initially ordered tube failed to remain stable. Aetna denied coverage for the specially designed tube, finding the device medically unnecessary. The physician then prescribed a different tube, which caused complications. Plaintiff sued Aetna in state court, alleging negligence. Aetna removed the action to federal court, and the court dismissed the action.

The Third Circuit affirmed in part and reversed in part. The appeals court held that plaintiff’s claim that Aetna interfered with his medical treatment is the type of claim that could be brought as an action for benefits under § 502(a) of ERISA and was thus completely pre-empted. On the other hand, the appeals court disagreed with the district court on that part of plaintiff’s state negligence action for alleged early discharge from the hospital. In the Court’s view, such a claim would not be encompassed in any relief available under § 502(a), and therefore would not be pre-empted. The Court remanded this aspect of plaintiff’s claim to the district court.

In reaching its decision, the court of appeals applied a framework it announced earlier in Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266 (3rd Cir. 2001), which held that, in reaching a decision on complete pre-emption, the central inquiry is whether claim “could have been” the subject of a civil enforcement action under section 502(a) of ERISA.

This case is significant because it highlights the developing jurisprudence on the subject of complete pre-emption under ERISA.

Fifth Circuit Finds Complete Pre-Emption Under ERISA in Case for Declaratory Relief to Protect Settlement from Subrogation

Plaintiff incurred injury from a car accident, and Ochsner Health Plan paid medical bills under the terms of an employee sponsored health plan offered by the employer of plaintiff’s mother. Plaintiff settled with three insurance companies for tort claims arising from his accident. The health plan covering plaintiff, and governed by ERISA, required plaintiff to notify the plan of any settlement of claims for which the plan had made payment. Plaintiff did not do so. The plan asserted a subrogation right to plaintiff’s personal injury cause of action, and sought reimbursement of benefits to the extent that plaintiff had received settlement compensation. In state court, plaintiff sought declaratory judgment that would have released Ochsner’s right of subrogation against the settlement proceeds obtained by plaintiff from the third party insurers. Ochsner removed case to federal district court, which found that it had subject matter jurisdiction because plaintiff stated a claim “to recover benefits” under ERISA § 502(a)(1)(B). A panel of the Fifth Circuit reversed.

The Fifth Circuit en banc affirmed the district court, finding that removal was proper. The appeals court construed plaintiff’s state law claim for declaratory relief as one “to recover benefits” due under the plan or a claim “to enforce rights” under the terms of the plan. The Fifth Circuit acknowledged that its prior decisions required a two-part test, mandating complete pre-emption and conflict pre-emption to find removal jurisdiction, but overruled this test and explicitly held that, for purposes of removal jurisdiction, only complete pre-emption of a claim under § 502(a) of ERISA is required. Arana v. Ochsner Health Plan, 338 F.3d 433 (5th Cir. 2003), cert. denied, 124 S. Ct. 1044 (Jan. 12, 2004).

This case is significant because it presents a different set of facts for the court’s consideration in the application of the complete pre-emption doctrine under ERISA, and it changes the rule in the Fifth Circuit for removal jurisdiction.

Fifth Circuit Affirms Dismissal of False Claims Act Action Against HMO Alleging Violation of Anti-Discriminatory Rules

Humana Health Plan entered into contracts with HCFA to provide healthcare services to Medicare beneficiaries. A qui tam relator alleged in a False Claims Act complaint that Humana engaged in a “cherrypicking” scheme, discriminating against certain Medicare participants. The district court granted Humana’s motion to dismiss.

The Fifth Circuit affirmed. The court noted that plaintiff’s overcharging theory was that the Humana improperly engaged in selective enrollments among counties. According to the court, this theory would not suffice to state a claim based upon plaintiff’s alleged cherrypicking scheme, because plaintiff failed to identify any false claim, or false record, which Humana used to get receive payment under the capitation method.
Next, the appeals court noted that the relator’s theory of liability under the FCA, implied certification, was one of first impression within the circuit. It declined to decide on the viability of that theory of liability. The court, though, wrote that even assuming that implied certification were to be embraced by the Fifth Circuit, there was lacking a factual basis for the plaintiff to prevail on the merits. The Fifth Circuit then addressed the allegation that Humana was culpable for fraud in the inducement. The Fifth Circuit acknowledged that, as a matter of law, FCA liability can exist when the contract was obtained initially through false statements, or fraudulent conduct. However, the court, wrote that plaintiff relied merely on a “one-sentence allegation, devoid of any factual information,” and thus, the court ruled that plaintiff’s allegation fell far short of the pleading requirements for fraud under Fed. R. Civ. P. 9(b).

United States ex rel. Willard v. Humana Health Plan, 336 F.3d 375 (5th Cir. 2003).

This case is significant because it addresses issues of proper pleading under the False Claims Act against the unique backdrop of contractual issues between HMOs and the federal agency administering the Medicare program.

Seventh Circuit Rules That ERISA Pre-Empts Rights of Subrogee
Under Wal-Mart’s self-funded health benefit plan, the plan paid medical expenditures, and the plan administrator retained subrogation rights. A Wal-Mart employee who was injured in a car accident sued the driver who caused her injuries. In contemplation of settlement, plaintiff filed a state action to adjudicate various liens on the lawsuit, including that of the plan. The plan administrator filed for removal to federal court. The district court declined jurisdiction, and the administrator filed a second federal action, asserting claims under ERISA § 502(a)(3)(B). The court enjoined plaintiff from proceeding in state court to adjudicate the administrator’s lien in state court. The court then granted the plan’s motion for summary judgment and determined that, under Illinois’ common fund doctrine, the administrator of the plan was to bear its proportional share of plaintiff’s attorney fees. The administrator appealed.

The Seventh Circuit held that, in relation to exercising its subrogation rights, an ERISA plan is not required to pay a proportionate share of attorneys’ fees incurred by a plan participant in her personal injury lawsuit under Illinois’ common fund doctrine. The court found that the common fund doctrine is pre-empted because it conflicted with the terms of the ERISA plan at issue and that ERISA requires that plans be administered in accordance with plan documents. The court also found that ERISA provided the health plan a cause of action to recover medical expenses from one of its participants who was already paid. The court reasoned that, in this instance, the participant held her settlement proceeds in a reserve, which made the funds sought by the plan under its subrogation clause identifiable and allowed it to seek appropriate equitable relief under ERISA’s civil enforcement scheme.

Administrative Committee of the Wal-Mart Stores v. Varco, 338 F.3d 680 (7th Cir. 2003).
This case presents novel issues, and was one of first impression before the court of appeals on the issue of the Illinois common fund doctrine, and ERISA conflict pre-emption.

U.S. Court in Pennsylvania Allows Some RICO Claims Against HMO and Its Operators
A physician and an affiliated professional corporation sued an HMO and its operators, alleging violations under the Racketeer Influenced and Corrupt Organizations Act (RICO). Plaintiffs alleged ways in which defendants had defrauded plaintiffs by wrongfully denying or delaying compensation under their HMO-physician contracts. Plaintiffs also asserted RICO claims, contending that defendants used economic fear of retaliation for objecting to wrongful delay and denial of payments due under the HMO-physician contract. Defendants moved for dismissal.

The U.S. Court for the Eastern District of Pennsylvania granted in part and denied in part. First, the court rejected defendants’ argument that Pegram v. Herdrich, 530 U.S. 211 (2000), barred the action. Second, the court rejected defendants’ McCarran-Ferguson defense, holding that “RICO does not,” as applied to the facts of the case, “invalidate, impair or supersede Pennsylvania’s insurance laws.” The court likewise rejected defendants’ argument that the state-action-immunity doctrine barred plaintiffs’ suit, emphasizing that such a defense was available only in limited circumstances within antitrust contexts, “where the activity sought to be immunized is unambiguously an intended, official state policy, actively supervised by state officials.”

Turning to plaintiffs’ RICO claims, the court found that plaintiffs had alleged some specific misrepresentations and omissions pertaining to their claims of mail and wire fraud with the requisite specificity. Additionally, the court let stand plaintiffs’ allegations of misrepresentations pertaining to quarterly bonuses. However, the court dismissed other claims, including one alleging that defendants “concealed that they systematically deny claims, and that defendants deliberately delay payments.”


The case is significant because it presents a number of novel questions of federal and state law.

U.S. Court in Louisiana Finds No Complete Pre-Emption Under ERISA for State Law Tort Claim for Wrongful Termination of Benefits
Plaintiff was covered by an Aetna health benefit plan. Aetna wrongfully terminated the health plan and subsequently denied coverage for plaintiff’s pre-approved surgery. Upon learning of the termination of the policy, plaintiff prematurely return to work, leading to additional injuries and the need for another surgical procedure. Plaintiff sued Aetna in state court, alleging bad faith. Aetna removed the case to federal court, which found it had jurisdiction and concluded that removal was proper. The court then granted summary judgment to Aetna on plaintiff’s breach of contract claim, explaining that, because plaintiff’s state law contract claim did not seek equitable relief, but rather
sought monetary damages, relief was “not available” under ERISA. The district court then addressed whether plaintiff’s state tort claims were also completely pre-empted. The court rejected Aetna’s argument that plaintiff’s claims for “improper claims processing” were essentially a “claim for a determination” of rights under the plan and concluded that the tort claims were not completely pre-empted. Alternatively, the court found that conflict pre-emption also did not apply to the tort claims because plaintiff’s claims sought “only money damages” for Aetna’s wrongful termination. Duchesne-Baker v. Extendicare Health Servs., Inc., No. 02-0590, 2003 WL 22327192 (E.D. La. Oct. 9, 2003).

This case is significant because it considers intricate issues associated with complete pre-emption, conflict pre-emption and the savings clause under ERISA.

U.S. Court in New York Finds ERISA Pre-Emption in Challenge to Utilization Review Decision
Empire Blue Cross arranged with Merit Behavioral Care Corp. to provide utilization review services. Merit Behavioral denied a participant’s request for coverage for inpatient psychiatric care. Thereafter, the participant attempted suicide. The participant then brought a state action against Empire Blue Cross and Merit Behavioral, alleging negligence in denying coverage for his illness. The state suit was removed to federal court.

The U.S. District Court for the Southern District of New York ruled that ERISA completely pre-empted the state law cause of action. The Court construed plaintiff’s claim for negligence in improperly declining treatment as being a claim more properly for denial of a plan benefit, rather than medical malpractice. Thus, the court found that ERISA completely pre-empted the negligence claim. In reviewing the instant appeal, the court acted pursuant to an order by the Second Circuit to reconsider plaintiff’s claims in light of Cicio v. Does, 321 F.3d 83 (2d Cir. 2003), which had held that a plaintiff’s action was not completely pre-empted by ERISA because it involved a mixed eligibility and treatment decision. The New York court distinguished Cicio from the instant facts, explaining that, in the instant case, the plan administrator had assumed no physician-patient relationship with the insured. Rather, its role was limited to informing a patient about coverage decisions. By contrast, in Cicio, the HMO participant’s agreement defined the HMO’s duties as providing enrollees with diagnosis and treatment of diseases. Rubin-Schneiderman v. Merit Behavioral Care Corp., No. 00 Civ. 8101, 2003 WL 22019833 (S.D.N.Y. Aug. 27, 2003).

The significance of this case is that it provides further insight into judicial analysis of the complete pre-emption doctrine as it applies to purely administrative decisions made by an administrator for a health plan.
U.S. Court in New Jersey Holds That ERISA Does Not Pre-Empt Negligence Action Against HMO Challenging Adequacy of its Perinatal Policy

The U.S. District Court for the District of New Jersey ruled that ERISA did not pre-empt an action by the parents of a child who was born prematurely and suffered severe disabilities against an HMO for negligently adopting and implementing its policy on home uterine activity monitoring. The court explained that plaintiff’s claims concerned the quality of medical treatment, and therefore were not completely pre-empted by ERISA. The basis for the court’s reasoning was that plaintiffs had charged that Aetna negligently adopted a policy for treating pregnant women having contractions and pre-term cervical dilation without adequately considering whether such a policy was medically appropriate. The court wrote that plaintiffs’ complaint could not be construed to allege that the healthcare plan made an administrative decision to deny a benefit due under the plan.


This case presents another court’s rationale, based on the facts of the case, for declining to find complete pre-emption under ERISA.

California Appeals Court Denies Claims By Physicians Against HMO

Physician groups that provided medical care to HMO enrollees sued HMOs to recover claims for medical services rendered. The physicians had submitted the claims to an independent practice association (IPA) that had contracted with the HMOs to process claims for payment. After the IPA became insolvent, the physicians unsuccessfully sought payment from the HMOs. In their lawsuit the physicians demanded payment for services rendered, alleging that the HMOs violated the California Knox-Keene Health Care Service Plan Act, which provides that a healthcare service plan “shall reimburse providers for emergency services . . .” until the enrollee is stabilized. The state court dismissed the action.

The California Court of Appeal affirmed, holding that the Knox-Keene Act did not create a private right of action to sue for damages. The appeals court also denied recovery under the physicians’ claim for unjust enrichment claim. The appeals court explained that, to recover under quantum meruit, the plaintiff must establish two elements: (1) plaintiff must have been acting pursuant to either an express or implied request for such services from defendant, and (2) the services rendered were intended to and did benefit defendant. In rejecting the unjust enrichment claim, the court construed the evidence such that the enrollees of the HMO presented themselves for emergency treatment, and were thus the beneficiaries of the services. Plaintiffs provided the medical services at the request of the patients, not the HMOs.


This case presents novel issues arising under the California Knox-Keene Health Care Service Plan Act, and under state common law.
New California Law Mandates Employer Funded Benefits
California recently enacted legislation mandating private employer-funded health benefits. The basic contours of the law set employer contribution rules based on the number of employees employed. For example, employers with 200 or more employees in California would, effective January 1, 2006, be required to choose between paying for comprehensive health insurance coverage for their employees and employee dependents, or, alternatively, elect not to provide such direct coverage, and instead make payments to a state-administered fund. The state fund would provide for healthcare insurance coverage to employees and their dependents. Those employers who choose to provide directly for health coverage would pay 80% of the costs, and the employee must pay the remaining 20%. For employers with fifty to 199 employees, the same rules would apply, as just noted above, except that coverage would be mandated for employees only, and not include dependents, as of January 1, 2007. For employers who employ twenty to forty-nine employees in the state, similar rules would apply as for employers employing fifty to 199 employees, except that their participation in the system would become operative if a tax credit program is enacted by the state legislature.

This action is significant because it represents direct action by a state legislature to ensure health coverage by companies for previously uninsured workers.

Tenth Circuit Lowers Deference to Benefit Decisions in Review of Potentially Conflicted Benefit Decisions
The Tenth Circuit has lowered the standard of deference afforded to the benefit decisions of plan administrators. An employee sued her plan administrator over the denial of long-term disability benefits after a staph infection rendered her disabled. The benefits were denied on the basis of a pre-existing coronary condition that may have caused the infection. Plaintiff exhausted her administrative appeals and then brought suit.

The appeals court determined that such administrators operate under an inherent conflict of interest because they both determine claims and pay claims. Therefore, the appeals court held that less deference is warranted to review of a denial of benefits under a plan.

Fought v. UNUM Life Ins. Co., 357 F.3d 1173 (10th Cir. 2004).

This case is significant because it lowers the level of deference a court is to afford to plan administrators’ benefits decisions.

Third Circuit Lowers Deference for Review of Potentially Conflicted Benefit Decisions
The Third Circuit Court applied a “slightly less deferential” standard of review to a claim by a plan subscriber against the plan for denial of coverage for an invasive surgical procedure that it deemed not medically necessary. The employee had suffered for ten years from temporo-mandibular joint disease (TMJ) and sought coverage for the procedure, which the employer/plan administrator rejected. Plaintiff
opted to have the surgery anyway, paid for it herself, and exhausted her appeals. While the administrator requested additional records, it ultimately determined that there were other appropriate procedures short of the invasive procedure that she chose.

The appeals court acknowledged a “slight” conflict of interest on the part of the employer, as it both administered and funded the plan. However, the appeals court also noted that the employer’s conflict was alleviated by the involvement of the plan’s insurer in the decision to deny benefits, which the employer upheld. The court found that this structure, in which the insurer makes the initial determination of coverage, “provides the safeguard of neutral evaluation.”


This case is significant because it lowers the level of deference a court is to afford to plan administrators’ benefits decisions.

California Appeals Court Allows Class Action Against Insurer for State-Law Breach of Contract Based on Rate Increase
The California Court of Appeal determined that Blue Cross could be sued for breach of contract and bad faith when it increased subscribers’ renewal rates based on the subscribers’ current age. A subscriber sued on behalf of herself and others, claiming that the relevant policies had promised renewal rates based on the subscribers’ initial age at the outset of the policy, but that Blue Cross has deviated from that promise and raised renewal rates based on the subscribers’ attained age upon renewal. The appeals court allowed a class action on these claims, but denied certification of the class on claims for fraud, negligent misrepresentation, and unfair business practices.

The California appeals court allowed a class action to proceed based on an insurer’s alleged breach of contract arising from a rate increase.

U.S. Court in North Carolina Finds Health Insurer’s Claim for Unpaid Fees and Premiums Was Entitled to Priority in Employer’s Bankruptcy Estate
The U.S. District Court for the Middle District of North Carolina affirmed the decision of a bankruptcy court that a health insurer’s claim for unpaid premiums and administrative fees and unreimbursed medical costs is entitled to priority under the bankruptcy law.

A furniture factory contracted with Great West Life & Annuity Insurance Co. (Great West) under a self-funded contract. Employees submitted claims to Great West, and Great West paid the claims and then was reimbursed from an account into which the company deposited funds. The factory closed its facility and offered its employees COBRA coverage, and Great West continued to pay claims. Subsequently, the factory filed for bankruptcy protection, and Great West sought to recoup sums owed to it.
Section 504(a)(4) of the U.S. Bankruptcy Code allows a priority claim on an employer’s bankruptcy estate assets for contributions to an employee benefit plan. The bankruptcy trustee of the bankrupt employer argued that the statute was intended to protect employees, not outside insurers. The bankruptcy court held that the insurer that provided benefits to the bankrupt’s employees during the time of financial difficulty did provide protection to the employees. In affirming, the federal district court observed that the health insurer that administered the plan and paid claims from its own funds until reimbursed by the employer “appears to play a significant part in that benefit plan. Accordingly, the plain language of the statute appears to include priority for an insurance company which has expended its own funds to make the plan work.” *Ivey v. Great West Life & Annuity Ins. Co.*, 308 B.R. 752 (M.D.N.C. 2004).

This case demonstrates a federal court’s affirming of priority status granted to a health insurer that had provided health benefits to a bankrupt company’s employees.
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I. CONTRACTS

Tennessee Supreme Court Says Hospital Had Authority to Enter into Exclusive Provider Agreement for Imaging Department and to Close Department to Medical Staff

Defendant radiologists applied for a certificate of need (CON) to perform outpatient imaging services in competition with Cookeville Regional Medical Center (CRMC), where defendants had staff privileges. CRMC, a private act hospital, is operated by the Cookeville Regional Medical Center Authority (Authority). The Authority opposed the application for the CON and decided to seek an exclusive provider for CRMC’s imaging department. After the provider chosen by CRMC obtained a CON, CRMC issued a request for proposal (RFP) for the contract to provide exclusive imaging services. Defendants’ radiology group opposed the RFP. CRMC filed an action seeking declaratory relief that it could close the imaging department to staff. Defendants counterclaimed that plaintiff was retaliating against them for obtaining the certificate of need, and asserted that CRMC lacked power under its bylaws to close the imaging department to medical staff.

The Tennessee Supreme Court determined that CRMC had the authority to enter into an exclusive provider contract, the result of which was the closing of the imaging department to medical staff. See Tenn. Code § 7-57-502(c), which gives a metropolitan hospital the authority to enter into a contract regardless of the competitive effect, and § 7-57-603, which gives private act hospitals the same powers that are granted to metropolitan hospitals. In addition, the high court determined that the hospital bylaws allow the Authority to enter into an exclusive provider agreement for business purposes, and the bylaws do not give defendants a reasonable expectation that they will be afforded notice and a hearing for a strictly business decision. Therefore, the high court held defendants had no protectable property interest in the loss of their privileges by the closing of the imaging department to the hospital staff.

City of Cookeville v. Humphrey, 126 S.W.3d 897 (Tenn. 2004).

Under Tennessee law, a private act hospital has the right to enter into an exclusive contract as long as such a contract is allowed under its bylaws, and physicians excluded as the result of that contract may not have a property interest in the loss of their privileges.
II. EMPLOYMENT ISSUES

Ninth Circuit Rules Hospital Employee Has No Fourth Amendment Expectation of Privacy in Hospital Mailroom

Customs officials with suspicions regarding a package addressed to a fictitious physician in a California hospital arranged with the Drug Enforcement Agency and hospital administration for a "controlled delivery" through the hospital mailroom, using a sensor that tracked the whereabouts of the suspect package and installing a covert video camera in the mailroom. That camera captured the defendant and a colleague "huddled" observing the suspect package in the mailroom, "celebrating," and moving the package out of normal delivery area. Defendant was eventually arrested and charged with possession with intent to distribute 3,617 grams of Ecstasy.

Defendant argued that a “temporary zone of privacy” existed when he was alone with his colleague in the mailroom. The Ninth Circuit ruled that defendant had no reasonable expectation of privacy in a hospital mailroom, and therefore, evidence obtained from a video camera in the mailroom was not the result of a “search” within the meaning of the Fourth Amendment. The court emphasized that property used for commercial purposes is treated differently from residential property, and although an individual can have a legitimate expectation of privacy in a commercial area, that expectation is less than one would have while on residential property. An individual whose presence on another’s premises is purely commercial in nature has no legitimate expectation of privacy in that location, and public hospitals, by their nature, are institutions not only accessible to the community, but places in which the needs of security and treatment create a diminished expectation of privacy.

U.S. v. Gonzalez, 328 F.3d 543 (9th Cir. 2003).

The court held that the public nature of a hospital precludes an expectation of privacy on the premises for purposes of the Fourth Amendment unless it is a hospital employee in a well-defined working area.

U.S. Court in Indiana Says ER Physician Alleged Sufficient Facts to Survive Dismissal of FCA Retaliation Claim Against Hospital and Medical Group

Plaintiff, an emergency room physician, began informing Medicare and Medicaid patients at Logansport Memorial Hospital (Hospital) that “it was inappropriate for them to come to the emergency room for colds and non-emergency medical conditions” based on his interpretation of 42 U.S.C. §§ 1320a-7 and 1320c-5, which makes it unlawful to provide medically unnecessary healthcare services to Medicaid and Medicare patients. The president of Logansport Emergency Physicians (LEP) warned plaintiff to stop the practice. Plaintiff asserts he was later terminated as a result of his reporting the alleged fraud and abuse. Plaintiff sued the Hospital and LEP (collectively “defendants”) in federal court, asserting a retaliation claim under the False Claims Act (FCA) whistleblower provision. Defendants moved to dismiss.

The U.S. District Court for the Southern District of Indiana denied the motion. First, the court rejected defendants’ argument that plaintiff’s actions were themselves unlawful
and therefore not protected by the FCA because his instructions to Medicare and Medicaid patients contravened the Emergency Medical Treatment and Labor Act. The court noted that plaintiff had not refused to treat Medicaid/Medicare patients presenting to the ER; rather, he merely informed them that it was inappropriate for them to come to the ER for non-emergency conditions. Next, the court concluded that plaintiff had alleged facts describing acts in furtherance of an FCA enforcement action. Although plaintiff had not threatened specifically to file a qui tam action, he had reported defendants’ allegedly fraudulent conduct. The court also found plaintiff had alleged facts showing defendants knew that he was engaged in protected conduct and that the discharge was at least partly motivated by the protected conduct.


A doctor who alleged he was terminated in retaliation for reporting the hospital’s attempt to maximize Medicaid and Medicare reimbursement by seeing inappropriate emergency room patients could assert a claim under the False Claims Act even if he did not file a qui tam suit, because his claims arose out of his reporting of alleged fraud and abuse to proper authorities.

**Fourth Circuit Holds Physician Failed to Prove Hospital Retaliated Against Him for Requesting Accommodation**

In June 1998, the chief (plaintiff) of the ultrasound department at Anne Arundel Medical Center (AAMC), suffered a heart attack. When plaintiff returned to work in September 1998, his doctor advised him to restrict his work, including not working overtime. Plaintiff claimed that when he informed AAMC of the restrictions, his weekly hours declined from seventy to forty and he was pressured to work overtime, which he occasionally did. Plaintiff also claimed that he was demoted to senior ultrasound technician and suspended for one day after a December 1999 incident in which he refused to work overtime. Plaintiff sued AAMC, claiming it refused to accommodate his disability for coronary artery disease as required by the Americans with Disabilities Act and demoted him in retaliation for requesting the accommodation.

The Fourth Circuit affirmed the district court’s summary judgment in favor of AAMC, emphasizing that plaintiff had to have shown he had a good faith belief that AAMC’s request that he work overtime was an unlawful refusal to reasonably accommodate his disability. For AAMC to refuse the accommodation, it had to be aware of the request for accommodation, and plaintiff could not have reasonably believed his earlier requests not to work overtime were outstanding at the time of the December 1999 incident. AAMC provided evidence that plaintiff worked overtime on several occasions shortly before December 1999, which he conceded he had done. The appeals court determined that plaintiff “could not have reasonably believed” AAMC should have known he was requesting an accommodation when he refused to work overtime. There also was nothing in plaintiff’s statement or actions the day he was suspended that would have led AAMC to believe he was requesting an accommodation. Plaintiff also failed to show AAMC’s proffered non-retaliatory reason for suspending him was a pretext for retaliation.

A hospital’s request that a physician with a heart condition work overtime was not a refusal to accommodate him under the ADA because it was not clear that the physician’s refusal to work overtime hours was a request for accommodation because he had worked overtime in the past.

III. EMTALA ACTIONS

U.S. Court in Wyoming Rejects EMTALA Claims of Patient Who Never Presented to Emergency Room and Failed to Show Hospital Had Actual Knowledge of Emergency Condition Before Discharge

Plaintiff went directly to hospital’s medical/surgery unit without stopping in the emergency room for a medical screening. The next morning, her doctor decided to discharge plaintiff after she told him she was feeling better, although she continued to experience some numbness and pain. On the following day, plaintiff experienced excruciating pain and was readmitted to the hospital, where another physician determined she had a large ruptured disc and that she was suffering from an extremely rare neurological disorder, a syndrome described as “the only true low back pain emergency.” Plaintiff sued the hospital in federal district court alleging it had violated the Emergency Medical Treatment and Active Labor Act (EMTALA) and was negligent in treating and discharging her. According to plaintiff, the hospital failed to properly screen and stabilize her emergency medical condition.

The court held that plaintiff’s claim that the hospital violated EMTALA’s medical screening requirement failed, regardless of whether it followed its standard procedures, because she never presented to the hospital emergency room as required by 42 U.S.C. § 1395dd(a). Next, the court rejected plaintiff’s argument that the hospital violated EMTALA’s stabilization requirement by discharging her with neurological abnormalities. According to the court, plaintiff failed to present any evidence that the hospital had actual knowledge of her unstable emergency medical condition when it discharged her. Once the hospital admitted plaintiff as an inpatient, it was liable to her under state tort law for negligent treatment.


EMTALA does not extend to a patient who never presented to a hospital’s emergency room and whose unstable condition was unknown to hospital staff.

Wisconsin Appeals Court Says EMTALA Stabilization Requirement Did Not Apply in Case in Which Patient Was Not Transferred

Plaintiff was twenty-three weeks pregnant when she gave birth at Meriter Hospital, Inc. (Meriter). Resuscitation and treatment were not provided, and the baby died. Plaintiff sued Meriter for claims including violation of the Emergency Medical Treatment and Labor Act (EMTALA). Plaintiff’s EMTALA claim was based on Meriter’s
failure to stabilize her child. The trial court granted Meriter’s motion for summary judgment. Plaintiff appealed.

The Wisconsin Court of Appeals affirmed, rejecting plaintiff’s argument that EMTALA required Meriter to stabilize her child regardless of whether the child was transferred to another hospital. The appeals court noted that it was an issue of first impression in Wisconsin whether, under EMTALA, a patient must be stabilized regardless of transfer. The appeals court found that, according to the Eleventh Circuit, EMTALA’s legislative history supported the plain language of the statute that it was meant to be a patient anti-dumping statute and did not provide for a federal malpractice tort claim. The appeals court thus held that EMTALA’s requirements are only triggered by a transfer and therefore did not apply in the instant case. The appeals court also rejected plaintiff’s argument that the trial court erred in holding she had not stated a violation of EMTALA’s screening requirement, noting that the plain language of EMTALA provides only for screening of patients who arrive at the emergency room with an emergency condition, and because plaintiff came to the birthing center rather than the emergency room, the screening requirement did not apply.


A patient who came to a hospital’s birthing center could not request protection under EMTALA’s requirement that a patient be stabilized before being transferred to another facility because EMTALA applies only to those who report to an emergency department and because her child, who was not stabilized, was not being transferred.

**IV. LIABILITY ISSUES**

**Fifth Circuit Says Plaintiff Had No Constitutional Claims for Receipt of HIV-Positive Blood**

Plaintiff sued Parkland Memorial Hospital (Parkland) in federal court after he received HIV-positive blood. Kinzie claimed Parkland was liable under 21 C.F.R. § 610.47, which creates an enforceable right under 42 U.S.C. § 1983. The district court dismissed the claims, and plaintiff appealed.

The Fifth Circuit, in an unpublished opinion, affirmed. The appeals court rejected plaintiff’s claim that he had an enforceable right under § 610.47, because that regulation did not become effective until after plaintiff learned of his HIV-positive status. Next, the appeals court determined that plaintiff had failed to state a substantive due process claim, finding instead that his allegations were for negligence and were “analogous to a fairly typical state-law tort claim.” Finally, the appeals court rejected the claim that Parkland’s training and supervision of its employees violated plaintiff’s constitutional rights. Those claims, the appeals court said, were based on Parkland’s liability, “which is immaterial because no constitutional violations occurred.”

**Kinzie v. Dallas County Hosp.** Dist., 239 F. Supp. 2d 618 (5th Cir. 2003).
The court rejected constitutional claims made by a patient who allegedly received HIV-positive blood because the occurrence took place before the effective date of the regulation under which he claimed his §1983 action, and his claims were more appropriate for a state-law tort suit.

Florida Appeals Court Finds Question of Fact as to Hospital’s Vicarious Liability for Radiologist’s Alleged Negligence as Apparent Agent
Klaus Roessler was admitted to Sarasota Memorial Hospital (Sarasota Memorial), through its emergency room. While an inpatient at the hospital, Roessler was taken to Sarasota Memorial’s radiology department for scans of his abdomen. Dr. Richard J. Lichtenstein, a board certified radiologist, interpreted the scans. Lichtenstein was an employee of a radiology group that contracted with the hospital to be the exclusive provider of radiology services there. Following surgery, Roessler suffered numerous complications, requiring him to stay in the hospital for over two months. Roessler sued Sarasota Memorial for medical malpractice based on vicarious liability. Roessler also alleged that Lichtenstein was an agent of Sarasota Memorial and that the negligence occurred while he was serving in that capacity.

The Florida District court of Appeal, Second District, reversed the grant of summary judgment, finding questions of fact on the issue of whether Sarasota Memorial could be held vicariously liable for Lichtenstein’s acts under a theory of apparent agency. The question of a physician’s apparent authority to act for a hospital is usually a question of fact for the jury. Here, Roessler was admitted to Sarasota Memorial through its emergency room as an inpatient. During his stay, the hospital provided him with services deemed necessary for his care, including professional radiological services that were provided through Sarasota Memorial’s radiology department. Sarasota Memorial assigned Lichtenstein to interpret the scans; Roessler did not attempt to secure his own specialist but instead accepted the physician provided by the hospital. These facts, the appeals court found, were sufficient to create a jury question on the issue of whether Sarasota Memorial could be vicariously liable under a theory that Lichtenstein was the hospital’s apparent agent.


It is an issue of fact as to whether a hospital can be held vicariously liable for the actions of a radiologist who was an independent contractor if the evidence could show that he was acting with apparent authority from the hospital when he allegedly committed malpractice.

Kentucky Appeals Court Says Hospital Not Liable for Wrongful Death Because Physician Was Independent Contractor
Plaintiffs, co-administrators of Marshall Carmine’s estate, sued Dr. Betty Lew Arnold, Dr. Mickey Anderson, and Flaget Memorial Hospital (collectively “defendants”) for wrongful death, alleging that defendants’ negligence led to Carmine’s death following complications from surgery. Five years after the suit was filed, plaintiffs discovered that an unnamed pathologist had misread tissue specimens, and Arnold and Anderson claimed that, if they had known the correct results, they would have
provided a different treatment for Marshall. Plaintiffs amended their complaint to include the pathologist.

The Kentucky Court of Appeals agreed with the trial court that the evidence supported a finding that the pathologist was an independent contractor. Specifically, the appeals court noted (1) that the pathologist is in a highly specialized practice area that usually has no supervision, (2) that he billed patients directly, (3) that his contract with the hospital suggested both parties believed he was an independent contractor, and (4) most importantly, the hospital had minimal control over the details of his work. Furthermore, the appeals court found the evidence supported the conclusion that the patient had adequate notice of the pathologist’s status because he had signed several forms on admission that included unambiguous statements that the physicians and pathologists at the hospital were independent contractors.


*An patient’s estate could not hold a hospital liable for the actions of a pathologist who acted as an independent contractor, as shown by the evidence at trial, and because the patient had ample notice that the pathologist was not an agent of the hospital.*

**California Appeals Court Holds Hospital Had No Duty to Locate Decedent’s Daughter Before Turning over Remains to County Coroner**

Decedent, who had been a nursing home resident for several years, died at Dameron Hospital (Hospital) from congestive heart failure and diabetes mellitus. The Hospital eventually turned over decedent’s remains to the county coroner for cremation after failing to find her daughter (plaintiff). Plaintiff sued the Hospital and the nursing home in state trial court, alleging negligent disposal of her mother’s body, conversion, and breach of fiduciary duty.

The California Court of Appeal disagreed with the lower court’s conclusion that a direct victim’s claim for negligent infliction of emotional distress requires the establishment of pre-existing relationship between the parties. Instead, the appeals court noted that a duty could be imposed by statute. However, the appeals court upheld the grant of summary judgment to the Hospital because no such duty arose under California law. The appeals court also found that the Hospital had not assumed a duty to plaintiff merely by its effort to locate decedent’s next of kin. Finally, it held that plaintiff’s conversion claim failed as a matter of law because the Hospital committed no wrongful act or disposition of decedent’s body, emphasizing that “not every failure to deliver property to the rightful owner constitutes a conversion.”


*In California, a hospital’s attempt to find a deceased patient’s next of kin did not establish a fiduciary duty to the kin, and delivery of the patient’s remains to the county coroner after the failed attempt to locate a next of kin did not constitute conversion.*
Indiana Appeals Court Says Medical Malpractice Act Did Not Create New Cause of Action for Wrongful Death of Fetus

Geneva Breece sought treatment for premature labor contractions at St. John’s Health System (St. John’s). An emergency caesarian section was performed after an ultrasound revealed twins, but only one heartbeat. One baby was born healthy, and the other was deceased. Breece and her husband (plaintiffs) sued St. John’s and various healthcare providers (defendants), claiming that their negligence caused the wrongful in utero death of her fetus. Defendants moved for partial summary judgment on the ground that the Child Wrongful Death Act (Child Act) precluded plaintiffs from bringing a wrongful death action. The trial court granted defendants’ motion for partial summary judgment and held that plaintiffs could not recover under the Child Act. Plaintiffs appealed.

The Indiana Court of Appeals affirmed on the issue of recovery under the Child Act. In so holding, the appeals court rejected plaintiffs’ assertion that, although there is no cause of action for the in utero death of a fetus under the Child Act, their claim was based on the Medical Malpractice Act (Malpractice Act). Based on the holdings in two previous Indiana cases, the appeals court held the Malpractice Act did not “create a new cause of action for the wrongful death of a fetus.”


Indiana’s medical malpractice law did not provide parents a cause of action for the death of a fetus, and unborn children were excluded under the Child Wrongful Death statute.

Kentucky Appeals Court Says Physician Was Independent Contractor and Not Employee Because Hospital Did Not Exercise Control over Physician

Plaintiff, on behalf of her minor son, sued Community United Methodist Hospital, Inc. (Hospital), for negligence in a physician’s treatment of her son in the Hospital’s emergency room. At trial, the Hospital moved for summary judgment on the ground that it was not vicariously liable for any of the physician’s actions because the physician was an independent contractor. The trial court granted defendant’s motion, and plaintiff appealed.

The Kentucky Court of Appeals affirmed. The appeals court noted that under the Restatement of the Law of Agency, nine factors must be considered in determining whether a person is an employee or an independent contractor. Reviewing the factors in the instant case, the appeals court observed that the physician and Hospital had entered into an agreement that stated that the physician was an independent contractor over whom the Hospital did not exercise control in connection with the physician’s professional work, and that the Hospital provided the physician workspace and supplies, but the physician obtained her own malpractice insurance. The appeals court thus found that the factors weighed in favor of a finding that physician was an independent contractor. Rejecting plaintiff’s argument that the general public does not know when entering an emergency department that the physicians are not employees of the hospital, the appeals court noted that plaintiff had signed a medical
authorization form that clearly stated that the physicians were independent contractors. The appeals court held that the medical authorization form’s contents, and plaintiff’s signing of the form, was conclusive evidence that the physician’s actions were not taken as an ostensible agent of defendant.


A hospital could not be held liable for alleged malpractice of doctor who was an independent contractor because the hospital and doctor had a contract noting her status, the hospital did not exercise control over her practice or actions, and the plaintiff signed an authorization form acknowledging this status.

V. PAYMENT ISSUES

**DHHS OIG Approves Use of “Preferred Hospital” Network in Medigap Policy**

The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) said it would not impose administrative sanctions under the Anti-Kickback Statute or the prohibition on inducements to beneficiaries in connection with an insurer’s proposal to use a “preferred hospital” network as part of a Medicare Supplemental Health Insurance (Medigap) policy. Under the proposal, the requestor, which offers multiple healthcare products, would indirectly contract with hospitals, through preferred provider organizations (PPOs), for discounts of up to 100% on Medicare inpatient deductibles incurred by its Medigap policyholders that the requestor would otherwise have to pay. The arrangements would apply only to the Medicare Part A deductible. The requestor would pay a fee to the PPO each time one of its policyholders received the discount from a hospital. The requestor would pay the full deductible as per the Medigap policy regardless of whether a policyholder was admitted to a network or non-network hospital. To promote use of network hospitals, the requestor would offer policyholders who use network hospitals for an inpatient stay a reduction in their next premium renewal. The PPO hospital networks would be open to any hospital.

The OIG noted that the proposed arrangement could potentially generate prohibited remuneration, but concluded that it would not impose administrative sanctions because the proposal presented a low risk of fraud or abuse while providing beneficiaries the potential for significant savings. Also, the OIG cited the proposal’s potential to lower Medigap costs for the requestor’s policyholders who select network hospitals, without raising costs for those who do not.


The OIG indicated it would allow a Medigap insurer to offer discounts through a preferred provider network despite potential for violations under the Anti-Kickback Statute because it posed a low risk of fraud and abuse and benefited beneficiaries without harming others.
South Dakota Supreme Court Rules Adult Children Not Liable to Hospital for Father’s Medical Expenses Under State Support Statute

Eight days before decedent was admitted to McKennan Hospital (Hospital), an insurance company deposited approximately $1.2 million into a trust for his needs to settle a personal injury claim. Unaware of the trust, the Hospital received Medicare benefits on Nelson’s behalf. During probate, the Hospital submitted a claim for balance of decedent’s account after Medicare payments, and the estate paid the claim. A Medicare audit later revealed that Nelson had been ineligible for Medicare during his medical treatment. Medicare recouped by setting off the payments it had made for Nelson’s care. After the estate was closed, the Hospital sued decedent’s adult children under S.D. Codified Laws § 25-7-27, which requires support from adult children who have the financial ability to provide necessary food, clothing, shelter, or medical attendance for a parent “who is unable to provide for himself.” The court granted summary judgment to the children. The Hospital appealed.

The South Dakota Supreme Court affirmed. The high court noted that the Hospital could have amended its claim after being notified of the Medicare recoupment because the estate had not yet been closed. At that time, the estate was solvent and could have paid the bill; therefore, Nelson was able to provide for himself within the meaning of the support statute. The high court also rejected the Hospital’s argument that, because Nelson was deceased when the bill came due, he was physically “unable to provide for himself.” The high court noted that it had in prior case law specifically held a showing of indigence, not physical inability, was key to establishing a cause of action under § 25-7-27.


A hospital could not recover costs of services provided to a now-deceased patient from his adult children under state law because, at the time of the hospital’s original bill, the patient was able to “provide for himself” under the law.

DHHS OIG Approves Joint Venture Ownership of Freestanding MRI Facility Located on Rural Hospital Investor’s Campus

The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) declined to impose administrative sanctions under the Anti-Kickback Statute in connection with the joint venture ownership of a freestanding magnetic resonance imaging center (MRI) located on the campus of a rural community hospital that owns roughly 30% of the venture’s partnership units. The venture did not fall within the safe harbors for small entity investments or for investments in medically underserved areas, but the OIG found a low potential for fraud and abuse.

The MRI center, operated by a limited partnership, is located in a rural area that is not medically underserved. All members of the medical community in the area, regardless of hospital affiliation, were offered limited partnerships. Returns on investment are directly proportional to capital contribution. Sixty percent of the center is owned by potential referral sources, including the nonprofit hospital, which owns 30% of the
partnership units and on whose campus the facility is located. Investors generated roughly 37% of the center’s revenues in 2000 and 2001. The hospital, which contracts with the center for MRI services, generated roughly 24% of total revenues, while investing physicians generated roughly 13% of total revenues.

The OIG found the arrangement possessed indicia of a legitimate business (all members of the surrounding medical community were offered the opportunity to invest on the same terms and conditions, investment returns were proportional to capital contributions, and less than 40% of the center’s revenue was derived from business generated by interested investors). In addition, the arrangement had none of the suspect characteristics identified with then-extant guidance regarding rural joint ventures. The OIG also found the arrangement was developed as a community-oriented effort to provide access to MRI services in the rural area and has provided a substantial community benefit.


*The OIG declined to impose administrative sanctions against a joint venture ownership of a freestanding MRI center.*

**DHHS OIG Declines to Impose Sanctions in Connection with Proposal For Joint Arrangement Between Hospital and Ambulance Company**

The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) concluded that a hospital and ambulance company’s proposal to provide emergency air ambulance services to trauma victims in a rural setting could potentially generate prohibited remuneration under the Anti-Kickback Statute, but that it would not impose administrative sanctions on the hospital or ambulance company.

The hospital is located in an area that has higher rates of mortality and disability for trauma victims than other parts of the state because of the considerable distances between emergency rooms and inadequate ground ambulance coverage. The hospital and ambulance company proposed to provide jointly for the emergency transport of trauma victims within the rural area. The OIG expressed concern that the hospital's provision of the helicopter landing pad, crew quarters, and related hospital resources without charge to the ambulance company implicated the Anti-Kickback Statute, but found minimal risks for federal healthcare program abuse based on a number of factors. First, the arrangement would relate to emergency services only, and therefore presented little risk of overutilization of federal healthcare programs. Second, the proposed arrangement should not result in steering patients to the hospital because referral patterns are governed by state and local protocols. Third, the proposed arrangement would be consistent with an EMS and trauma care system that seeks to regulate, improve, and safeguard the provision of EMS and trauma care in the area. The hospital resources such as the landing pad and crew quarters would also be available to all ambulance companies. Fourth, the proposed arrangement is likely to have a positive impact on the quality of patient care in the area.

The OIG found that, despite the potential for prohibited remuneration under the Anti-Kickback Statute, an arrangement between a hospital and ambulance service was allowable because the proposal related only to emergency services, would not result in patient steering, and would improve trauma services in the area.

Kansas Supreme Court Holds Hospital May Not Offset Written-Off Medical Expenses Pursuant to Medicare Against Damages Judgment in Beneficiary’s Negligence Action

A hospital may not offset medical expenses it wrote off pursuant to Medicare’s payment against a damages judgment in a negligence action brought by the estate of a former Medicare beneficiary, the Kansas Supreme Court has ruled. The court held that the trial court’s decision granting the hospital’s setoff motion directly conflicted with Medicare law, which prohibits healthcare providers from charging beneficiaries for items or services that are not covered by Medicare. The high court also held, on an issue of first impression, that the trial court properly denied the hospital’s motion to limit the evidence of medical expenses to those amounts actually paid by Medicare, without including the amounts it wrote off. According to the high court, the common law collateral source rule, which provides that benefits received by an injured party from sources independent of the wrongdoer should not diminish damages otherwise available from the wrongdoer, applies to a healthcare provider’s medical bills that are written off pursuant to a contract with Medicare.

The high court held that the collateral source rule applies to Medicare write-offs. “Because health care providers voluntarily contract with Medicare in the same manner as they contract with other private insurers for reduced rates, the benefit of the write-offs should be attributed to the Medicare participant rather than the health care provider,” the high court wrote. Moreover, public policy in Kansas supports the theory that any windfall from the injured party’s collateral sources should flow to the injured party rather than the tortfeasor. Accordingly, the high court held that the trial court did not err in its judgment on this issue.


Because the common law collateral source rule applies to Medicare write-offs, providers cannot attempt to offset write-offs made pursuant to a Medicare contract, and the benefit of the write-off should go to the patient, not the hospital.

PRRB Affirms Intermediary’s Adjustments to Physician Stand-By Costs in Routine Area of Hospital

The provider, a psychiatric hospital, contracted with various physicians to provide an on-site physician presence in the routine area of the hospital. The provider claimed the physicians’ stand-by costs for emergency services on its cost report. The fiscal intermediary disallowed these costs on the basis that the provider did not have a formal emergency room on the premises. Because the Provider Reimbursement
Review Board (Board) found that neither the regulations nor the manuals cited by the parties defined “emergency room,” it reviewed the Emergency Medical Treatment and Active Labor Act (EMTALA) interpretive guidelines and held there was a sufficient basis to find the provider rendered emergency services to its patients. However, the Board also found the provider had failed to meet regulatory and manual documentation provisions required for reimbursement. The Board thus concluded there was no basis for recognition of the provider’s stand-by costs and affirmed the intermediary’s adjustments.


*The PRRB found that a provider that did not have a formal emergency room could be reimbursed for stand-by emergency physicians because it rendered emergency services to its patients, but denied reimbursement in this case because the provider did not meet the regulatory and documentation provisions required for reimbursement.*

**DHHS OIG Approves Proposed Reintegration Of Medical Group And Hospital**

The Department of Health and Human Services Office of Inspector General (OIG) said it would not impose administrative sanctions under the Anti-Kickback Statute in connection with a proposal to reintegrate a medical group and a hospital that were originally a single entity. The proposal calls for the hospital and the group to enter into a ten-year professional services agreement (PSA), under which the group will be the exclusive provider of professional services in a new hospital outpatient clinic that will largely serve the group’s existing patients and also work in the hospital’s emergency room. The hospital will pay the group a fee for its services, which will be consistent with fair market value in an arms’ length transaction. In addition, the hospital will enter into an agreement with the group to provide it various administrative and billing services. The vast majority of the group’s revenues after reintegrating with the hospital will come from the PSA.

Although the proposal could potentially generate prohibited remuneration under the Anti-Kickback Statute, the OIG declined to impose administrative sanctions, noting that he most remuneration in the proposal—the transfer of the Group’s assets to the Hospital “flows in the same direction as the most obvious referral pattern—the physicians’ referrals of their patients to the Hospital.” Thus, the OIG said it would focus its analysis primarily on the ancillary transactions and other potential remuneration opportunities. The OIG said that the exclusive PSA could be problematic, but found it unlikely that the PSA would result in much new business for the group. The OIG also found it unlikely that the proposal would generate impermissible remuneration from the hospital to the group in exchange for the group’s referral of patients to the hospital.

The DHHS OIG concluded that the proposal to merge a physician group and a hospital would not violate the Anti-Kickback Statute because the arrangement was not structured in such a way that the group would gain much new business or experience impermissible remuneration.

U.S. Court in Massachusetts Holds Government Failed to Exhaust Administrative Remedies Before Bringing Suit to Recover Alleged Overpayments

Defendant University of Massachusetts Memorial Medical Center provided services to Medicare beneficiaries and billed Medicare for those services, which the Department of Health and Human Services (DHHS) approved and paid. After a nationwide investigation of Medicare billing, the Department of Justice (DOJ) sued defendant on allegations that defendant had received overpayments for outpatient services to Medicare beneficiaries and sought recoupment of the overpayments. Defendant moved to dismiss or, in the alternative, for judgment on the pleadings based on lack of subject matter jurisdiction because the government had failed to exhaust its administrative remedies.

The U.S. District Court for the District of Massachusetts granted defendant’s motion. The court noted that, at oral argument, the government had argued that administrative exhaustion was unnecessary once the DOJ had initiated the investigation, determined there were overpayments, and removed the inquiry from DHHS. Defendant argued that, because the government was seeking judicial review of the DHHS Secretary’s reimbursement determination, the action was barred by the jurisdictional limitations of 42 U.S.C. §405(h). The government argued § 405(h) only applies to actions brought against the United States.

The court noted that the question of whether the jurisdictional limits of § 405(h) apply to actions brought by the United States was an issue of first impression. Section 405(h) provides that no decision of the Secretary will be reviewed except as provided by the section, and the court observed that nothing in § 405(h) suggested that review was limited to actions brought against the government. Because the government failed to exhaust its administrative remedies, the court granted defendant’s motion to dismiss.


The court held that the government must exhaust administrative remedies before filing an action to recoup overpayments to a hospital because 42 U.S.C. § 405(h), requiring parties to exhaust administrative remedies, applied to actions brought by the government as well as action brought against it.
VI. UTILIZATION REVIEW/PRO

U.S. Court in Illinois Holds Hospital Documents on Improving Patient Care Are Not Discoverable Under Self-Critical Analysis Privilege

After Provena Saint Joseph Medical Center (Provena) terminated her employment, plaintiff sued Provena on a claim that she was terminated in retaliation for reporting alleged fraud in the billing of Medicare and Medicaid. Plaintiff moved to compel production of certain discovery requests under Fed. R. Civ. P. 26(b). Defendant opposed the motion on the ground the requested documents were not relevant or were privileged.

The U.S. District Court for the Northern District of Illinois granted in part and denied in part plaintiff’s request. Plaintiff had requested production of inter-company documents about complaints, investigations, and Assignment Despite Objection Forms (ADOs). Defendant responded by claiming that self-critical analysis privilege protected the ADOs and other similar documents. The court noted that, in applying the privilege, a court must balance the public interest in protecting corporate self-assessments and a plaintiff’s need for all the relevant documents. The court determined that the purpose of the disputed documents was to identify ways to improve patient care. Because the public has an interest in the free flow of such information, defendant has a legitimate concern that the ADOs will be used against it, and the documents were prepared with the expectation that they would be confidential.


Hospital documents created to identify ways of improving patient care were not discoverable under the self-critical analysis privilege because they were prepared with an expectation of privacy, and encouraging the free flow of information by shielding a hospital from the concern that such discussions could be used against it was in the public interest.

VII. MISCELLANEOUS

Texas Appeals Court Says Release of Blood-Alcohol Test Results Is Permissible Under HIPAA When Disclosure Is for Law Enforcement Purposes and Is Pursuant to Grand Jury Subpoena

Derek Harmon drove a car into a concrete barrier and was taken to the hospital. The officer on the scene smelled alcohol on Harmon’s breath and found two tumblers containing alcohol inside his car. The officer obtained a grand jury subpoena for Harmon’s medical records from the hospital, which showed he had a blood-alcohol content of .18. After the trial court denied his motion to suppress the blood test results, Harmon pleaded guilty to driving while intoxicated. Harmon appealed.

The Texas Court of Appeals affirmed, holding that Harmon lacked standing to challenge the grand jury subpoena because he had no reasonable expectation of
privacy in the blood-alcohol test results taken by hospital personnel solely for medical purposes. Citing previous case law, the appeals court held that the Fourth Amendment did not confer a reasonable expectation of privacy under such circumstances. The appeals court also rejected Harmon’s argument that the grand jury subpoena under which his information was obtained violated the Health Insurance Portability and Accountability Act (HIPAA), commenting in a footnote that the HIPAA privacy regulations were not in effect at the time Harmon’s records were obtained by grand jury subpoena. Finally, the court held that, even if the subpoena was overly broad as Harmon argued, none of the other information was used by the state in the plea-bargaining process. Thus, the appeals court rejected Harmon’s argument on this point as well and affirmed the judgment of the trial court.


A patient who claimed that the release of blood alcohol level information held by the hospital violated HIPAA did not have standing to challenge the subpoena requesting such information, and HIPAA did not protect the information as it was being used in this circumstance.

**Kentucky Appeals Court Says Public Hospital Overstepped Its Authority in Creating Private Foundation with Public Funds**

The Calloway County Fiscal Court sought declaratory and injunctive relief in state trial court after the Murray-Calloway County Public Hospital (Hospital), a public, nonprofit corporation, created the Community Healthcare Foundation, Inc. (Foundation), a private entity, using public funds. The Hospital was created in the 1960s through the joint action of the Fiscal Court and the City of Murray with public funds. In 1997, the Hospital decided to create the Foundation to conduct certain of its healthcare-related activities. The Foundation was partly funded using public funds transferred from the Hospital. The Fiscal Court objected to the Hospital’s divestiture and reallocation of public funds. It adopted a resolution that the transfer of funds was not in the public interest and did not serve public purposes. According to the Fiscal Court, the Hospital’s establishment of the Foundation violated the state constitution.

The appeals court held that the trial court erred in failing to recognize the binding legal effect of the Fiscal Court’s determination that the transfer to the Foundation did not serve a public purpose. It found nothing in the Hospital’s articles of incorporation giving it the authority to form and fund a separate corporation or to divest itself of public funds. Rather, authority over the public Hospital rested with the Fiscal Court, the appeals court concluded. Thus, the appeals court vacated the trial court’s judgment and remanded for further consistent proceedings.


A public hospital could not create a private foundation using public funds because it was bound under the authority of the Fiscal Court under the Kentucky state
constitution, and a court should recognize that body’s conclusion that the Foundation did not serve a public purpose.

Fifth Circuit Reverses Lower Court; Sends St. David’s to Trial
One of the key developments in recent years in the joint venture analysis for tax-exempt hospitals was the district court decision in St. David’s. In that case, the court granted summary judgment overturning the Internal Revenue Service revocation of the tax-exempt status of a nonprofit healthcare organization participating in a joint venture. Although the case involved a whole hospital joint venture, many held out hope that its flexible approach might ultimately lead to similarly flexible guidance for ancillary joint ventures as well. The latest St. David’s decision, however, puts something of a damper on joint ventures, at least of the whole hospital variety.

In an opinion released on November 7, 2003, the Fifth Circuit vacated the decision for the taxpayer in St. David’s and remanded the case for a full trial. The primary issue on appeal was whether material fact, i.e., whether any key facts that could affect the outcome, were in dispute. The appeals court found that there were. Those disputed facts related to one part of the operational test for exemption: whether St. David’s is engaged primarily in activities that benefit its exempt purpose. The parties agreed that, because St. David’s had contributed all of its medical facilities to the partnership, the activities of the partnership would determine whether St. David’s satisfies the operational test for exemption. In assessing compliance with the operational test, the Fifth Circuit focused on control rights at various levels, including the importance of day-to-day management and the likelihood of the nonprofit actually enforcing its various rights under the partnership documents.

St. David’s Health Care Sys. v. United States, 349 F.3d 232 (5th Cir. 2003).
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I. ALTERNATIVE DISPUTE RESOLUTION

California Appeals Court Says State Law Regulating Arbitration Is Not Pre-Empted by Federal Law

Plaintiff was enrolled in PacifiCare of California’s Medicare+Choice healthcare plan when she was diagnosed with Bell’s palsy. Dissatisfied with care and treatment rendered under the plan, she sued PacifiCare. PacifiCare petitioned to compel arbitration. The lower court denied the petition and held that the arbitration provision did not comply with the requirements of the Cal. Health & Safety Code § 1363.1. PacifiCare appealed, and the issue before the Court was whether § 1363.1 was pre-empted by federal law, thereby mandating arbitration.

The California Court of Appeal, Fourth Appellate District, in an unpublished decision, affirmed the trial court’s judgment and concluded, relying in part upon Zolezzi v PacifiCare of California, 105 Cal. App. 4th 573 (2003), that, where § 1363.1 does not relate to state standards for coverage determinations, it was not pre-empted by the Medicare Act’s pre-emption of coverage determinations. The appeals court further rejected the applicability of the Medicare Act provision pre-empting state standards and requirements related to marketing materials and summaries of benefits regarding Medicare+Choice, where that provision was enacted after the commencement of the instant action. Finally, the appeals court determined that the Federal Arbitration Act did not pre-empt § 1363.1, where the § regulates the business of insurance within the meaning of the McCarran-Ferguson Act, which precludes pre-emption of state laws regulating insurance.


State law provision governing arbitration is not pre-empted by Medicare law or the Federal Arbitration Act where it is unrelated to coverage determinations and or marketing under Medicare, and regulates the insurance business as set forth by the McCarran-Ferguson Act.

California High Court Says Claims for Injunctive Relief Not Subject to Arbitration When Relief Sought by Injunction Was Designed as Public, Rather than Private Benefit

Plaintiff filed a class action against PacifiCare Health Systems, Inc., and PacifiCare of California, Inc. (collectively “defendant”), on behalf of himself and approximately 1.6 million PacifiCare enrollees, claiming that defendant had engaged in schemes to discourage its primary care physicians from delivering quality healthcare. Specifically, plaintiff alleged that defendant engaged in false advertising, commission of unfair, unlawful, or fraudulent business acts, violations of the Consumer Legal Remedies Act,
and unjust enrichment. Plaintiff sought injunctive relief and restitution. Defendant moved to compel arbitration based on the language of its subscriber agreement. The trial court denied defendant’s request, and the appeals court affirmed.

Upon review of this case before the California Supreme Court, it was affirmed and reversed, in part. The high court concluded that, as a general rule, requests for injunctive relief designed to benefit the public presents a narrow exception to the Federal Arbitration Act’s requirement that state courts honor arbitration agreements. Thus, the court found that plaintiff’s claims for false advertising and unfair competition were not subject to arbitration because the request for injunctive relief was clearly for the benefit of the healthcare consumers and the general public. However, the high court held that restitutionary claims, unlike claims for the public benefit, were subject to arbitration because the benefits of such claims inure to plaintiffs, rather than the general public. 

*Cruz v. PacifiCare Health Sys., Inc.*, 133 Cal.Rptr.2d 58 (Cal. 2003).

*Claims for injunctive relief under the Consumer Legal Remedies Act are not subject to arbitration under the Federal Arbitration Act because the relief is designed as a public rather than private benefit.*

**Colorado High Court Says Notice Provisions for Arbitration Clauses in Medical Services Contracts Are Exempt from Federal Pre-Emption**

Plaintiff’s husband was an enrollee of Kaiser Foundation Health Plan of Colorado who died as a result of alleged medical malpractice. The medical services contract of the health plan required enrollees to arbitrate any medical malpractice claims, including claims for death asserted by members, heirs, or personal representatives. Following her husband death, plaintiff commenced an action against her husband’s treating physicians and their employer, which was under contract with Kaiser to provide services to its members. Plaintiff asserted a claim of wrongful death, and defendants moved to compel arbitration, arguing that plaintiff was an heir under the agreement between Kaiser and her husband and therefore bound by its arbitration clause. The trial court agreed, and the Colorado Court of Appeals reversed and held that plaintiff was not a party to the agreement, and further that her action was wholly separate and distinct from any action her husband might have maintained.

The Colorado Supreme Court affirmed, but on different grounds. The supreme court held that, while the arbitration provision’s scope did extend to wrongful death actions filed by members non-party spouse, plaintiff was not bound by the provision where it failed to comply with the Colorado Health Care Availably Act (Act) requirement of certain notice language and type face in medical services agreements. Importantly, the supreme court acknowledged that the Act was exempt from pre-emption by the Federal Arbitration Act pursuant to McCarran-Ferguson, because it was enacted for the purpose of regulating the business of insurance.

Arbitration clauses in medical services contracts are exempt from federal pre-emption under the McCarran-Ferguson Act if such notice clauses were enacted for the purpose of regulating the business of insurance.

Alabama High Court Says Insurance Dispute Is Subject to Arbitration Where Policies Affect Interstate Commerce
Edward and Bernice Smith, Alabama residents, purchased Medicare supplemental insurance policies from Health Insurance Corporation of Alabama (HICA), headquartered in Montgomery, Alabama. The corporation faxed the Smiths’ insurance application to Olympic Health Management Systems, which manages HICA’s Medicare supplemental insurance policies in Bellingham, Washington. As a third-party administrator of the policies, Olympic made all decisions regarding coverage and handled any subsequent customer communications and claims administration from its Washington location. In June 2001, the Smiths, individually and as members of a punitive class, filed suit against HICA in state trial court, alleging breach of contract, fraud, suppression, negligent misrepresentation, civil conspiracy to defraud, and breach of fiduciary duty. HICA moved to compel arbitration pursuant to an arbitration clause in the Medicare supplemental insurance policies, arguing the Federal Arbitration Act (FAA) governed the policies because they substantially affected or were in the flow of interstate commerce. The court denied the motion, and HICA appealed.

The Alabama Supreme Court held that the insurance policies substantially affected interstate commerce because HICA was an Alabama company with the majority of its administrative activities occurring in Washington. As such, the policy was subject to arbitration under the FAA. **Health Ins. Corp. v. Smith**, 869 So.2d 1100 (Ala. 2003).

Arbitration pursuant to an arbitration clause in a supplemental insurance policy may be compelled where the policy substantially effects or is in the flow of interstate commerce and thus subject to the Federal Arbitration Act.

Alabama High Court Finds Nursing Home Administration Agreement Has Substantial Impact on Interstate Commerce.
Zadie Gibson sued McGuffey Health and Rehabilitation Center in state trial court for medical malpractice arising from a fall from her bed at the nursing home. McGuffey sought to compel arbitration pursuant to the terms of Gibson’s admission agreement. Defendant’s motion was denied, and the trial court concluded that, because the admissions agreement did not substantially affect interstate commerce, the malpractice action should not be subject to arbitration under the Federal Arbitrations Act (FAA).

The Alabama Supreme Court reversed the decision of the trial court and held that the admissions agreement had a substantial effect on interstate commerce and was therefore subject to the FAA because the Medicare funds used to pay for Gibson’s care originated with the federal government and passed through the State of
Nebraska before reaching Alabama, where Gibson resided in McGuffey Nursing Home.

**McGuffey Health and Rehabilitation Ctr. v. Gibson, 864 So.2d 1061 (Ala. 2003).**

*Medicare funds moving across state lines should be considered to establish the interstate commerce element required to determine whether parties should be subject to arbitration under the Federal Arbitration Act.*

**Idaho Supreme Court Holds Bad Faith Claim Was Subject to Arbitration**

Peggy Lovey purchased a health insurance policy from Regence BlueShield of Idaho. Lovey claimed the agent that sold her the policy informed her that coverage commenced on December 12, 2000. On December 13, 2000, Lovey’s doctor determined that she needed bypass surgery on her abdominal aorta. BlueShield declined to pay because it contended the coverage began on December 14, 2000. Lovey sued BlueShield on claims of breach of contract and bad faith. BlueShield moved to dismiss the action. The trial court denied the motion to dismiss on the ground the arbitration clause was unconscionable.

The Idaho Supreme Court granted an interlocutory appeal and reversed. The high court noted that the validity of an arbitration provision must be determined under contract law, and for a provision to be voided as unconscionable it must be procedurally and substantively unconscionable. The high court rejected the trial court’s reasoning that the contract was unconscionable, finding no evidence that Lovey did not have an opportunity to read the contract, that there was no explanation of the arbitration clause, or that the clause was “hidden” in the contract. The high court then determined, on an issue of first impression, that Lovey’s bad faith claim could only be established by an analysis of the policy, and therefore her claim came within the arbitration clause as “arising out of or relating to” the policy. Accordingly, the high court reversed the trial court’s judgment that the arbitration clause was unenforceable, and remanded the case for further proceedings.

**Lovey v. Regence BlueShield, 72 P.3d 877 (Idaho 2003).**

*A bad faith claim could only be established by an analysis of the policy, and therefore came within the arbitration clause as “arising out of or relating to” the policy.*

**Florida Appeals Court Says Nursing Home Admissions Contract Was Not Unconscionable**

Plaintiff, as the personal representative of the estate of Isabella Brooks, sued Gainesville Health Care Center, Inc. (defendant), alleging negligence and wrongful death. Defendant moved to compel arbitration and abate the proceedings based on the admissions contract for defendant’s nursing home. The admissions contract had been signed by Brooks’ daughter pursuant to a power of attorney. Plaintiff argued the arbitration provision was procedurally and substantively unconscionable. The trial court held the admissions contract was procedurally and substantively unconscionable because no one explained the contract to Brooks’ daughter, and denied the motion to compel arbitration and abate the proceedings. Defendant appealed.
The Florida District Court of Appeal reversed, finding that plaintiff had failed to show that the arbitration provision was unconscionable. The appeals court noted that the Federal Arbitration Act (FAA) and the Florida Arbitration Code both provide that a contract may be avoided if it is unconscionable, and observed that, to be unconscionable, a contract must be both procedurally and substantively unconscionable. In this case the trial court had found the admissions contract to be unconscionable because Brooks’ daughter could not make a “meaningful choice” about the contract because no one had explained its terms to her. However, the appeals court noted that the daughter had had the opportunity to ask questions about the contract, which she did not do, and that the contract was not presented on a “take-it-or-leave-it” basis in which she was pressured to sign without reading. The appeals court also held that, because plaintiff had failed in her burden of proving the arbitration clause was procedurally unconscionable, it did not have to decide if the arbitration provision was substantively unconscionable.


An arbitration clause in Florida must be both procedurally and substantively unconscionable.

**Florida Appeals Court Finds Nursing Home Arbitration Agreement Unenforceable Because It Deprived Residents of Statutory Rights**

A nursing home arbitration agreement that was signed by the husband of a resident was unenforceable because it contained provisions that defeated the remedial provisions of Florida’s Nursing Home Resident’s Rights Act (Act). The arbitration agreement at issue prevented the resident from vindicating statutory rights in the arbitral forum that was specifically contemplated by the legislature in enacting the statute to reduce elder abuse in nursing homes. The Florida District Court of Appeals, Fourth District, held that this arbitration agreement was unenforceable because it was substantially unconscionable to a great degree and involved some degree of procedural irregularity in its formation. The appeals court found that the arbitration agreement would deprive nursing home residents of the remedies provided in the Act. The arbitration agreement signed by the resident prevented the arbitrator from awarding attorney’s fees or punitive damages under any circumstances. Thus, the appeals court concluded that the arbitration agreement did not permit the resident to vindicate statutory rights and took away any effective enforcement of those rights, which are counter to a resident’s statutory rights.


An arbitration agreement is unenforceable if it deprives nursing home residents of statutory rights.
Ninth Circuit Holds Agreement Between Employer and Union About Election Was Subject to Arbitration

Service Employees International Union and Service Employee International Union, Local 399, entered into an agreement with Catholic Healthcare West (CHW) and its subsidiaries that set forth rules the parties would follow during a union organizing drive. Pursuant to the agreement, the union invoked the right to have the National Labor Relation Board conduct a secret ballot election. The election was conducted in September 2001, and the majority of the votes were against the union. In October 2001, the union sent a letter to CHW, alleging several violations of the agreement during the organizing campaign. The union asserted its rights to arbitration of the dispute. CHW disagreed, and the union sued to compel arbitration. The Ninth Circuit held in favor of the union and entered an order to compel arbitration. The appeals court noted that the agreement states that any unresolved disputes under the agreement will be submitted for arbitration. The union’s allegations arose during the time of the agreement, and therefore, the arbitration clause applied.

**Service Employees Int’l Union v. St. Vincent Med. Ctr.,** 344 F.3d 977 (9th Cir. 2003).

An arbitration clause in a union and employer agreement will hold if it contains an arbitration provision and the allegation arose during the term of the agreement.

Michigan Appeals Court Remands Case for Determination of Whether Collective Bargaining Agreement Was in Effect

Plaintiff, a state medical care facility, believed that the first of two collective bargaining agreements with defendant union did not apply regarding the change in a retirement plan. The issue before the Michigan Court of Appeals was whether or not the original collective bargaining agreement or the second collective bargaining agreement applied to this situation. The trial court had found that the original collective bargaining agreement had expired, and that the second collective bargaining agreement applied retroactively. However, the appeals court found that, because both parties disputed the facts and circumstances of the case, the case had to be remanded for the trial court to determine whether the second collective bargaining agreement was in effect when the grievance was filed.


Disputed facts and circumstances regarding a collective bargaining agreement are properly sent to the trial court to determine conclusively the facts and circumstances of the case.

California High Court Says Contractual Arbitration Right Is Not Waived Merely Because of Lawsuit to Declare Contract Void

PacifiCare of California sued Saint Agnes Medical Center to declare one of the health services contracts between them void. The California Supreme Court held that the filing of such a lawsuit, without more, does not result in a waiver of a party’s right to seek arbitration under a contract. The supreme court noted that state law reflects a
strong policy favoring arbitration agreements and emphasized that those seeking to establish waiver bear a heavy burden of proof. The high court concluded that the mere fact that PacifiCare had filed the action to have its contract with Saint Agnes declared void without first seeking arbitration did not, by itself, waive PacifiCare’s right to seek arbitration of the action brought by Saint Agnes.


This case demonstrates that the mere filing of a contract voidance lawsuit does not result in the waiver of a party’s right to pursue arbitration under the contract at issue.

Sixth Circuit Holds That Party to Contract Did Not Waive Arbitration During Negotiations

In 1997, John Deere Health Plan, Inc., a health maintenance organization, entered into an agreement with Wellmont Health Systems to provide medical services to John Deere members. In 2001, John Deere and Wellmont entered into another contract, which contained an arbitration clause that the 1997 contract had not contained. A dispute between the parties arose after John Deere performed an audit and believed that Wellmont was overpaid $1.3 million. Wellmont contended that, because the 2001 contract contained a clause that the terms of the 1997 contract remained in effect and the 1997 contract did not contain an arbitration clause, there was a conflict. According to Wellmont, because the two contracts conflicted, the absence of an arbitration clause in the 1997 contract prevailed. However, the Sixth Circuit found Wellmont’s reasoning flawed because the 1997 contract provisions on hospital services did not remain in effect when the 2001 contract including the arbitration clause superseded the 1997 contract for those services. Thus, there was no conflict and the arbitration clause applied to hospital services.


A previous contract provision does not remain in effect when a subsequent contract is executed.

Maryland High Court Holds Arbitration Agreement Was Unenforceable for Lack of Consideration Because Employer’s Promise Was Illusory

In November 2000, United Healthcare of the Mid-Atlantic hired plaintiff as a senior sales executive. In its job offer letter, United enclosed summaries of its internal dispute resolution and arbitration policy. On his first day of work, plaintiff received an employee handbook that included the internal dispute resolution and arbitration policy. The arbitration policy stated the scope and rules of arbitration and included a summary noting that arbitration was the final and exclusive way to resolve a dispute.

In July 2001, United terminated plaintiff, and plaintiff sued United for breach of contract and other claims. United moved to dismiss and compel arbitration. On appeal, the Maryland Court of Appeals held that the arbitration agreement was unenforceable based on lack of consideration, because United’s promise to arbitrate was illusory.
An arbitration agreement is unenforceable for lack of consideration when an employer promise to arbitrate is illusory.

South Carolina Appeals Court Says Federal Arbitration Act Governed Dispute About Physician Recruiting Agreement
Plaintiff and defendant entered into a “recruiting agreement” in which plaintiff agreed to relocate his medical practice as a cardiovascular surgeon from Michigan to South Carolina. Plaintiff left the service area prior to the four-year commitment and refused to return the recruitment incentives pursuant to the recruitment agreement, which contained a binding arbitration provision. Defendant requested arbitration, and plaintiff refused on grounds that the Federal Arbitration Act (FAA) did not apply because his recruitment agreement did not involve interstate commerce. The trial court held that the arbitration provision was not enforceable under South Carolina’s Uniform Arbitration Act and that the recruitment agreement did not implicate the FAA because the transaction between the parties did not involve interstate commerce.

The South Carolina Court of Appeals reversed, concluding that the recruiting agreement involved interstate commerce. The appeals court found that the agreement involved monetary inducement to move from Michigan to South Carolina, such as payment of plaintiff’s moving expenses from one state to another. The appeals court concluded that the “performance of the recruiting agreement requires activity involving interstate commerce.” Citing Selama Med. Ctr., Inc. v. Fontenot, 824 So.2d 668 (Ala. 2001), a case involving a recruitment agreement for two physicians to relocate their practice to another state in exchange for monetary guarantees which included an arbitration provision, the appeals court found that, with recruitment agreements where physicians move from one state to another in exchange for monetary incentives, the recruitment agreement affects interstate commerce and the FAA applies. Thornton v. Trident Med. Ctr., L.L.C., 592 S.E.2d 50 (S.C. Ct. App. 2003).

The Federal Arbitration Act governs recruitment arrangements across state lines because the exchange of money to induce a physician to leave one state to relocate in another involves interstate commerce.

Alabama Supreme Court Holds Personal Representatives Suing for Wrongful Death Are Bound by Arbitration Provisions in Nursing Home Admissions Agreement
Personal representatives of two deceased nursing home residents were held to be bound by the arbitration provisions in the admissions agreement that were signed by the residents’ agents. Upon entering the nursing home, agents for the two residents had signed admissions agreements containing arbitration provisions for resolving disputes between the parties.

The Alabama Supreme Court held, in this consolidated action, that the arbitration provisions contained in the admissions contracts applied to the personal
representatives. The high court noted that the parties were seeking to impose duties that arose from the admissions contract while seeking to avoid the arbitration provisions of the same contracts under which they sought recovery. Furthermore, the high court concluded that the admissions contracts substantially affected interstate commerce in that there were several out-of-state patients, the nursing home received supplies from out-of-state, and the decedents were Medicare patients. Based on such facts, the high court concluded that the arbitration provisions were enforceable.

The dissenting opinion argued that the personal representatives were non-signatories to the nursing home admissions agreement and should not be bound by them. The dissent agreed with the trial court that the wrongful death statute creates a new cause of action that does not derive from decedents' rights and “because the right to bring a wrongful death action arises only after the death, a living person is without authority to bind his or her future personal representative to arbitrate that personal representative's claim for wrongful death.”


An arbitration provision in an admissions agreement is enforceable against future personal representatives.

Alabama Supreme Court Says Nursing Home Resident Was Bound by Terms of Arbitration Agreement
When decedent entered the nursing home to undergo rehabilitation following hospitalization for heart failure, decedent’s daughter signed the admissions form, which included an arbitration provision for resolving disputes between the parties.

The Alabama Supreme Court, in affirming the trial court’s decision, held that the decedent’s daughter clearly signed the admissions agreement as decedent’s family member and there was no evidence presented to demonstrate that the decedent objected to such execution of the admissions agreement. Moreover, the high court determined that the agreement was for an underlying transaction involving interstate commerce and that the Federal Arbitration Agreement thus applied and pre-empted state law. Accordingly, the high court affirmed the trial court order compelling arbitration pursuant to the terms of the admissions agreement.


Admissions agreements signed by family members of patients will be bound by the terms of the agreement, including the arbitration provisions.
II. INDIVIDUAL/PATIENT RIGHTS

Tenth Circuit Allows Disclosure of Peer Review and Quality Assurance Records to Patient Advocacy Groups For Mentally Ill

Plaintiff Center for Legal Advocacy, a designated patient and advocacy system for the mentally ill in Colorado, sought access to hospital records and documents related to four suicide deaths at the Colorado Mental Health Institute at Pueblo. Specifically, pursuant to the 1986 Protection and Advocacy for Mentally Ill Individuals Act (PAMII), 42 U.S.C. §10801, plaintiff sought a declaratory judgment and injunctive relief that it was legally entitled to both the patients' medical records and certain hospital peer review and quality assurance materials. The Colorado Department of Health and Human Services and the Colorado Mental Health Institute at Pueblo turned over all patient records, but argued that state law prevented disclosure of peer review and quality assurance materials. A federal court in Colorado held that PAMII does not pre-empt the Colorado peer review privilege, and as such, the act grants access to patient records but does not include hospital peer review materials. Plaintiff appealed.

The Tenth Circuit reversed and held that PAMII requires disclosure of the peer review and quality assurance records. Specifically, under PAMII, protection and advocacy systems like plaintiff have access to all records of any individual, and the term "records" includes the reports prepared by any staff of the facility rendering care or treatment or reports prepared by any agency charged with investigating reports of instance of abuse, neglect and injury and the steps taken to investigate such instances. The appeals court concluded that the term "record" included peer review and quality assurance.

Center for Legal Advocacy v. Hammons, 323 F.3d 1262 (10th Cir. 2003).

Disclosure of peer review and quality assurance records to patient advocacy groups for the mentally ill is permissible pursuant to the 1986 Protection and Advocacy for Mentally Ill Individuals Act (PAMII).

U.S. Supreme Court Allows Forced Medication to Render Mentally Ill Competent for Trial Only in Limited Circumstances

Defendant Dr. Charles Sell, who has a history of mental illness, was indicted on charges of mail fraud, Medicaid fraud, and money laundering in connection with allegedly false claims submitted by his dental practice. After several incidents in court, a magistrate judge found Sell incompetent to stand trial and ordered his hospitalization at the U.S. Medical Center for Federal Prisoners. Two months later, the medical center sought to administer anti-psychotic drugs to Sell against his will. After various administrative hearings, Sell filed a motion in court contesting the involuntary administration of the drugs. The magistrate judge issued an order authorizing the administration of the anti-psychotic drugs, citing Sell as a danger to himself and others. Sell appealed, and a federal district court found the magistrate judge’s dangerousness finding “clearly erroneous,” but affirmed the order approving the involuntary administration of the drugs. Both Sell and the government appealed, and the Eighth Circuit affirmed the judgment that Sell was not dangerous but that he
should be forcibly medicated in order to render him competent to stand trial. Sell again appealed the matter.

The U.S. Supreme Court, in a 6/3 decision, held that the Constitution permits the government to administer drugs involuntarily to mentally ill defendants so that they may be competent to stand trial, but only in very limited circumstances. According to the Court, in order to forcibly administer anti-psychotic drugs to a defendant, the treatment must be (1) medically appropriate, (2) substantially unlikely to have side effects that may undermine the fairness of the trial, and (3) necessary to further important governmental interests. 


*Forced medication is permissible to render mentally ill patients competent for trial only when the treatment is medically appropriate, substantially unlikely to have side effects that may undermine the fairness of the trial, and necessary to further important governmental interests.*

**U.S. Court in Florida Says Informed Consent Is Not Needed for Use of Donated Tissue in Medical Research**

Plaintiffs sued defendants for lack of informed consent, breach of fiduciary duty, unjust enrichment, fraudulent concealment, conversion, and misappropriation of trade secrets after defendant, using plaintiffs' blood and tissue samples, engaged in research that resulted in the filing of a patent application for the Canavan genetic sequencing, which was granted in October 1997. Plaintiffs sought damages for financial contributions and the royalties paid to defendants, and a permanent injunction restraining defendants from enforcing their patent rights. Defendants moved to dismiss, arguing that the doctrine of informed consent applies only to medical procedures and does not extend to research results.

The U.S. District for the Southern District of Florida concluded that, although Florida consent law does not apply to medical research, it does apply to any genetic analysis of a person’s tissue. However, the court declined to extend the informed consent duty for medical research to disclosure of a financial interest, and dismissed the count for failure to state a claim.


*Informed consent is not necessary to use donated tissue in medical research because the doctrine does not extend to disclosure of researcher’s financial interest in a particular study to research participants.*

**Texas Appeals Court Says Release of Blood-Alcohol Test Results Is Permissible Under HIPAA When Disclosure Is for Law Enforcement Purposes and Is Pursuant to Grand Jury Subpoena**

Derek Harmon drove a car into a concrete barrier and was taken to the hospital. The officer on the scene smelled alcohol on Harmon’s breath and found alcohol inside his
car. The officer obtained a grand jury subpoena for Harmon’s medical records from the hospital, which showed he had a blood-alcohol content of .18. After the trial court denied his motion to suppress the blood test results, Harmon pleaded guilty to driving while intoxicated. Harmon appealed.

The Texas Court of Appeals affirmed. First, the appeals court said Harmon lacked standing to challenge the subpoena because he lacked a reasonable expectation of privacy in the blood-alcohol test results taken by hospital personnel solely for medical purposes. The appeals court found that the Fourth Amendment did not confer a reasonable expectation of privacy under such circumstances. The appeals court also rejected Harmon’s argument that the subpoena under which his information was obtained violated the Health Insurance Portability and Accountability Act (HIPAA), explaining that, “if HIPAA imposes a new statutory right of privacy that trumps the State’s power to issue grand-jury subpoenas in a criminal investigation, disclosure of medical records under HIPAA is permissible without an individual’s permission when the information is disclosed for law enforcement purposes and is obtained pursuant to a grand-jury subpoena.”


*Disclosure of an individual’s medical record is permissible without consent if the information is disclosed for law enforcement purposes pursuant to a grand-jury subpoena.*

**New Jersey Appeals Court Says Shield Law Protects Videotape of Treatment but Any Part of Videotape That Defendant Intends to Use at Trial Must Be Produced**

In July 2001, plaintiff was treated in an emergency room. NYT Television, a division of The New York Times Company (collectively “NYT”), was in the emergency room videotaping a television show called “Trauma: Life in the E.R.” NYT taped plaintiff’s treatment but never aired the footage. Although plaintiff signed a consent form for the taping, he later claimed that he was heavily medicated when he signed. Plaintiff sued NYT for invasion of privacy. During discovery, plaintiff requested that NYT produce any photos or videotape depicting his treatment. NYT objected, citing a statutory newsperson’s privilege, also known as the Shield Law. The trial court ordered production of the videotape of the treatment, and NYT appealed.

The Superior Court of New Jersey, Appellate Division, reversed the order requiring NYT to produce all of the videotape, but affirmed the production of any videotape that NYT planned to introduce at trial. The appeals court held that the Shield Law applies to all information that is part of newsgathering activities, and it was irrelevant that the videotape was not used for the television show. The appeals court also rejected plaintiff’s alternative argument that the Shield Law did not apply because the television show was not “news” and the NYT was not “news media.” The appeals court found that the statute provides broad definitions of “news media” and “news” and noted that the videotape had educational and public policy aspects that brought it under the
definition of “news.” Next, the appeals court observed that plaintiff’s claim involved only private parties and did not involve any governmental action. Therefore, the appeals court held that the invasion of privacy claim did not have any “constitutional roots.”


The Shield Law was not intended to give the news media an advantage at trial, and was intended to protect the gathering of news. The law applies to all information that is part of newsgathering activities, whether or not the information is broadcast.

The California Court of Appeal affirmed. The appeals court explained that, although CMIA prohibits disclosure of a patient’s health information without the patient’s authorization, the statute contains an exception under which, if an inquiry has been made about a specific patient, a provider may provide any general information about the patient. The court determined there was “a legislative intent to permit disclosure of general information without imposing burdensome paperwork or administrative requirements on medical providers.” The appeals court noted that the exception explicitly allows for such disclosure without the patient’s permission. The appeals court then turned to the issue of whether the information Young disclosed fell within the exception. The appeals court clarified that “medical information” may include general information about the nature of the injury, the reason for treatment, and the condition of the patient. According to the appeals court, the trial court had initially stated it might need expert testimony to determine if Young’s disclosures were within the exception, but had later determined Young’s testimony was the “expert medical opinion,” and plaintiff had made no attempt to contest Young’s testimony on the issue. The appeals court also noted that plaintiff had talked about suffering from stress with coworkers and other third parties, and such disclosures were “appropriately seen as a waiver of rights in a lawsuit against a medical provider for violation of the CMIA.” The appeals court concluded plaintiff failed to present sufficient evidence that Young had violated the CMIA.


A statutory exception allows for the disclosure of general patient information without the patient’s permission to employers.
Missouri Appeals Court Finds Transplant Company Immune from Liability for Bone, Tissue Removal, but Says Action Against Hospital and Nurse May Proceed Because of Dispute on Consent

After Frank Schembre Sr. died at Jefferson Memorial Hospital, a hospital nurse, Christopher Guelbert, approached Schembre’s wife and children (plaintiffs) about organ donation. Plaintiffs agreed to donate Schembre’s corneas and bones from his legs. Plaintiffs contended that Guelbert did not tell them that procuring the corneas would involve the removal of the entire eyeball. Plaintiffs also asserted that Guelbert said the amount of bone removed from Schembre’s leg would be roughly two to four inches. The consent form signed by plaintiffs did not indicate any of these restrictions. Mid-America Transplant Services (MTS) performed the removal pursuant to its protocols. Before harvesting the eye and bones, an MTS manager reviewed the consent form and found it unambiguous and valid on its face. Plaintiffs sued MTS, the hospital, and Guelbert in state trial court. The trial court granted defendants summary judgment on the ground of Uniform Anatomical Gift Act (UAGA) immunity, which protects “[a] person who acts without negligence and in good faith.” Plaintiffs appealed.

The Missouri Court of Appeals affirmed as to MTS, but reversed as to the hospital and Guelbert. The appeals court found that MTS acted “without negligence” because it had relied on a facially valid consent form and followed all standard protocols. Next, citing the fact that MTS relied on a facially valid consent form signed by decedent’s wife, and without any apparent limitations, the appeals court concluded that MTS met its burden of showing it acted in “good faith” and thus was entitled to UAGA immunity. However, the appeals court reversed summary judgment in favor of the hospital and Guelbert. According to the court, the record reflected a factual dispute as to the representations Guelbert had made to plaintiffs. Noting that both parties had given substantially different accounts of the discussion, the appeals court concluded that these issues were to be resolved by the trier of fact.


Actions taken in good faith and without negligence are immune from civil liability under the Uniform Anatomical Gift Act (“UAGA”).

Connecticut Supreme Court Says Trial Court Must Consider Defendant’s Fair Trial Rights Before Ordering Him Involuntarily Medicated So He Can Stand Trial

Defendant was charged for simple trespass, breach of the peace, assault of a police officer, and carrying a dangerous weapon. The trial court found defendant incompetent to stand trial. The trial court ruled, pursuant to Conn. Gen. Stat. § 54-56d(k)(2) and State v. Garcia, 658 A.2d 573 (Conn. 1995), that the state had met its burden of proof to have defendant involuntarily medicated. Defendant appealed, claiming that the forced medication would violate his rights under the First, Sixth, and Fourteenth Amendments of the U.S. Constitution. The appeals court concluded that defendant’s First and Sixth Amendment rights were implicated, but, applying Garcia, confirmed the trial court’s order on the basis that the involuntary medication would
serve the government’s interest while protecting defendant to the extent possible. The state challenged the appeals court’s conclusion that defendant had First and Sixth amendment rights that the trial court must consider during a hearing pursuant to § 54-56d(k)(2).

The Connecticut Supreme Court vacated the appeals court’s judgment and ordered that the case be remanded to the trial court to consider defendant’s fair trial rights when deciding whether to authorize involuntary medication. The high court noted that, under Sell v. United States, 123 S. Ct. 2174 (2003), a trial court must consider a defendant’s fair trial rights, which are encompassed by the Sixth Amendment. Because the trial court applied the Garcia standard, which differs from that set forth in Sell, the high court concluded that the case must be remanded to the trial court for further proceedings. Connecticut v. Jacobs, 828 A.2d 587 (Conn. 2003).

A defendant’s constitutional fair trial rights must be considered when deciding whether to authorize involuntary medication.

Massachusetts Appeals Court Says Negligent Failure to Obtain Consent to Surgical Procedure Was Not Unfair Trade Practice
Defendant physician performed a hemorrhoidectomy on plaintiff. Before surgery, plaintiff had signed a consent form, which she later admitted she had not read, that authorized a fissurectomy. Plaintiff was informed in the recovery room that a hemorrhoidectomy and not a fissurectomy had been performed. Immediately following surgery, plaintiff experienced extreme pain, which she attributed to the hemorrhoidectomy. After follow-up treatment, defendant performed a second surgery on plaintiff and discovered that one of the wounds from the hemorrhoidectomy had not healed. Plaintiff sued defendant, alleging simple battery and failure of informed consent because she had signed a consent form authorizing only a fissurectomy. The Massachusetts Appeals Court determined that plaintiff’s claim was only for the negligent failure to obtain her consent, and there was nothing in defendant’s conduct or actions that was unfair or deceptive. Accordingly, the appeals court held that, while physician may be negligent in failing to obtain informed consent, such actions do not constitute an unfair or deceptive practice. Darviris v. Petros, 795 N.E.2d 1196 (Mass. App. Ct. 2003).

While a physician may be negligent in failing to obtain informed consent, such actions do not constitute an unfair or deceptive practice.

First Circuit Reverses Dismissal of Privacy Claim Against Physician Because His Relationship with Patient Was Unclear
Plaintiff had a discussion with a coworker about guns, revenge, life and politics. The coworker reported the conversation to management, which suspended plaintiff. Management then consulted with a physician and contacted the local police. Management later fired plaintiff, citing its zero tolerance policy for workplace violence. As plaintiff left following termination, waiting police officers told him he was being
involuntarily committed to a hospital for observation. Plaintiff was released after three days in isolation, when the hospital concluded he posed no threat to himself or others. Plaintiff sued management for various claims, including one for violating his right to privacy. The lower court dismissed the privacy claim in addition to all other claims.

The First Circuit affirmed the dismissal except for the privacy claim. The appeals court decided to remand the privacy claim in order to answer questions regarding management’s relationship with the physician, what management told the physician, what the physician’s records showed about plaintiff’s condition, what lead the physician to conclude that information should be released to management or to the police, and what information the physician actually released. Physician’s relationship with plaintiff must be cleared up before a final determination of the privacy claim can be made.

**Andresen v. Diorio,** 349 F.3d 8 (1st Cir. 2003).

**California Appeals Court Holds Wife May Not Recover Emotional Distress Damages for Husband’s Treatment That Affected In Vitro Fertilization Procedure**

Plaintiff husband’s physician prescribed Flomax to treat an enlarged prostate. Two months after he began taking Flomax, the husband was unable to produce a sperm specimen as part of an in vitro fertilization procedure. An urologist at the fertility clinic determined that the husband’s inability to produce a sperm specimen was a side effect of the Flomax. Husband and plaintiff wife sued physician for negligence in prescribing Flomax.

The California Court of Appeal agreed with the trial court in dismissing all claims. Plaintiffs’ claim of negligent infliction of emotional distress failed on the grounds that plaintiff was not a direct victim because physician never treated her and physician’s treatment of husband did not affect her health. Further, plaintiffs could not proceed under a bystander theory of liability because the wife did not observe physician’s treatment of her husband.


*In order for a claim of emotional distress to survive, a plaintiff must be a direct victim of treatment provided by a physician.*

**Utah Appeals Court Says Plaintiff Must Present Expert Testimony to Support Medical Malpractice Claim Based on Abandonment**

Plaintiff was referred to defendant, an endodontist, for a root canal. Plaintiff signed a consent form, and defendant took x-rays and administered a local anesthetic. Defendant examined plaintiff and determined that she needed the root canal, but refused to perform the procedure after it was determined that plaintiff could not pay for the procedure and did not qualify for a payment plan. Plaintiff sued defendant for medical malpractice on the claim of abandonment. Defendant claimed that no abandonment occurred because treatment had not commenced. The trial court granted summary judgment and noted that plaintiff needed to establish her claim by expert testimony on the issue of when treatment began.
The Utah Court of Appeals affirmed the grant of summary judgment, explaining that a physician has a duty to exercise ordinary care not to discontinue treatment once it has begun. The appeals court explained that, once it is established when treatment began, a fact-finder must determine if the physician exercised reasonable care in discontinuing the treatment. Because a layperson does not have the medical knowledge to determine if a physician’s actions constituted treatment, the appeals court held that expert testimony was required for plaintiff’s claim of abandonment. Newman v. Sonnenberg, 81 P.3d 808 (Utah Ct. App. 2003).

*Medical expert testimony is required when determining when medical treatment has commenced.*

**D.C. High Court Says Physicians in Same Medical Office Who Communicated About Patient’s HIV Status Did Not Violate Patient Confidentiality**

Defendant was plaintiff’s treating physician and was privy to information about plaintiff’s HIV-positive status, which was noted in his medical records. At a later time, plaintiff claimed to defendant that a physician (Physician) in defendant’s medical office had molested him during an office visit. Defendant investigated and wrote a memorandum about the incident to the Physician, which included information about plaintiff’s HIV positive status. The Physician was aware of plaintiff’s HIV status because plaintiff had informed the Physician about his status during a prior office visit. Plaintiff sued defendant for breach of the physician-patient confidential relationship. The trial court granted defendant’s motion for summary judgment.

The District of Columbia Court of Appeals affirmed. Based on the evidence presented, the court concluded that both defendant and the Physician knew about plaintiff’s HIV status and that the memorandum was part of a communication between two physicians in the course of dealing with the issues that arise in a medical office. The high court concluded that the memorandum communicated the concerns that had been raised by the patient to one physician about another physician in the medical office and therefore related to the operation of the medical office. The court opined that defendant did not disclose any confidential information about plaintiff to the Physician that was not already known to the Physician. Suesbury v. Caceres, 840 A.2d 1285 (D.C. 2004).

*A communication concerning operational issues between physicians in the same medical office about a patient does not violate physician-patient confidentiality.*

**California Appeals Court Says Emergency Medical Technicians Owed No Duty of Care to Woman Who Fled Ambulance and Was Killed in Road**

After acting strangely, plaintiff’s wife was voluntarily transported to the hospital by emergency medical technicians (defendants). After arriving at the hospital, plaintiff’s wife ran away from the ambulance and was struck and killed by a car on the road near the hospital. Plaintiff sued for negligence, and a trial court granted summary judgment in favor of defendants.
The California Court of Appeals affirmed, finding that plaintiff failed to present any evidence establishing a special relationship between his wife and defendants. Determining that defendants owed no duty to plaintiff’s wife, the appeals court applied the holding in *Rowland v. Christian*, 69 Cal.2d 108 (Cal. 1968), and found no causal connection between defendants’ conduct and plaintiff’s wife’s death. *Hernandez v. KWPH Enters.*, 10 Cal.Rptr.3d 137 (Cal. Ct. App. 2004).

*EMTs have no duty of care where there is no evidence of a special relationship or evidence of a duty to protect.*

**U.S. Court in Pennsylvania Upholds Amended HIPAA Privacy Rule**

Plaintiffs, a group of nine individuals and ten organizations, challenged the Health Insurance Portability and Accountability Act (HIPAA) privacy rule as amended to remove the original provision that covered entities must obtain patient consent before using their protected health information for treatment, payment, and healthcare operations.

The U.S. District Court for the Eastern District of Pennsylvania found that the Secretary of Health and Human Services had adequately considered the two factors mandated by Subtitle F of HIPAA—efficiency and effectiveness of healthcare system and the privacy of health information—when deciding to amend the rule. Further, the court found that the Secretary acted within his statutory authority provided by HIPAA. The court also concluded that the notice of proposed rulemaking for the amended rule had adequately informed the public of the intent to rescind the consent requirement. Accordingly, the court held that the amendment to the HIPAA privacy rule did not violate the Administrative Procedure Act or constitutional rights. *Citizens for Health v. Thompson*, No. 03-2267, 2004 WL 765356 (E.D. Pa. Apr. 2, 2004).

*This case demonstrates that the HIPAA privacy rule, as amended, is alive and well.*

**U.S. Court in Maryland Says HIPAA Applies to Ex Parte Communications with Treating Physician**

Plaintiff sought to bar a treating physician from discussing plaintiff’s treatment with defense counsel or, alternatively, to require defense counsel to disclose all communications with the treating physician and provide details of the treating physician’s expert testimony. At trial, plaintiff objected to ex parte communications during discovery that may have occurred between plaintiff’s treating physician and defense counsel.

The U.S. District Court for the District of Maryland held that the Health Insurance Portability and Accountability Act (HIPAA) pre-empted the Maryland Confidentiality of Medical Records Act (MCMRA) and, therefore, controlled ex parte communication. The court noted that HIPAA pre-empts contrary state laws unless they are “more stringent” than HIPAA requirements. The court advised litigators to be more cautious.
in their contact with medical fact witnesses when compared to other fact witnesses to ensure that they do not run afoul of HIPAA regulatory scheme.  

*HIPAA pre-empts contrary state laws unless they are more stringent than HIPAA requirements. HIPAA governs ex parte communications with the treating physician of a patient in a medical malpractice action.*

**III. MEDICAL MALPRACTICE**

**New Causes of Action**

**Massachusetts High Court Rules Charitable Damages Cap Applies Despite Hospital's Negligent Record Keeping**

Plaintiff sued Brigham and Women's Hospital, Inc., for medical malpractice, alleging that defendant failed to diagnose and treat him for sepsis and meningitis after his birth, resulting in profound brain damage. Defendant asserted as an affirmative defense that the statutory damages cap of $20,000 against charitable corporations was applicable. During discovery, defendant refused to produce names, addresses, licenses and certifications of individuals involved in plaintiff's care and further refused to produce plaintiff's medical record. As a result, the court ordered that defendant be defaulted as to liability and its immunity defense stricken on the grounds that the missing records were critical to proving plaintiff's claim. Thereafter, plaintiffs were awarded $4 million in damages, but the jury refused to award damages of loss of enjoyment of life. Both parties appealed.

The Massachusetts Supreme Judicial Court affirmed the default judgment against defendant on the issue of liability, but vacated the $4 million judgment as to damages, holding that the $20,000 statutory cap applied. With regard to the default sanction, the high court explained that, although the matter should have been disposed of under the spoliation doctrine, which is applicable to parties who negligently or intentionally lose or destroy evidence, the fact that defendant failed to maintain the records and provide them to a patient on request is a violation that itself gives rise to liability as a form of malpractice. With regard to the damages issue, the court concluded that the plain language of the statute limits the amount of civil damages available against charitable corporations that cause harm by committing a tort in the performance of their charitable purpose, and it cannot be stricken on the grounds that is unfair to achieve an equitable result.  

*The charitable damages cap set forth by a Massachusetts statute is applicable in medical malpractice cases despite a finding of liability on the part of the hospital for malpractice.*
Arizona Supreme Court Holds State Medical Malpractice Statute Section on Battery Action Unconstitutional

Prior to a scheduled magnetic resonance imaging examination, plaintiff advised nurse on three occasions that she would only accept Demerol or Morphine for sedation, as opposed to Fentanyl. Notwithstanding her request, plaintiff was given the Fentanyl without her knowledge and suffered serious complications. Plaintiff sued Scottsdale Medical Imaging (SMI) and Hospital Radiologist, Inc., alleging medical malpractice, lack of informed consent, and battery based on her refusal to accept Fentanyl. Prior to trial, plaintiff moved to dismiss the medical malpractice and lack of informed consent claims, but moved for summary judgment on the battery claim. In response, SMI argued the battery claim was barred by the Medical Malpractice Act and cross-moved for summary judgment.

Upon review of the matter by the Arizona Supreme Court, the high court addressed two issues. First, with regard to the battery claim, the high court held that a healthcare provider commits a battery if the provider performs a medical procedure on a patient without consent, and under the facts of the case presented, a battery had occurred. Second, with regard to the bar on battery claims set forth by the Medical Malpractice Act, the high court concluded that, to the extent the Act abolished the right to bring a battery action, thereby limiting medical malpractice actions without providing reasonable alternatives, it is an unconstitutional abrogation of a patient’s right to sue in battery and as such is unconstitutional.


*Where the Medical Malpractice Act abolishes a patient’s right to bring a battery action against a healthcare provider, and limits medical malpractice actions without providing a reasonable alternative for a battery action, it represents an unconstitutional abrogation of a patient’s right to sue in battery.*

Texas Supreme Court Holds in Issue of First Impression That Physician Was Not Liable Under Good Samaritan Statute Because There Was No Expectation of Remuneration

Plaintiff was admitted to St. David Medical Center to have a labor induction that had been scheduled by her attending physician, Dr. Patricia Gunter. Thereafter, Gunter left the labor and delivery area. When the nursing staff paged for a doctor, Dr. Douglas McIntyre, who was visiting one of his own patients, answered the page and delivered the baby. Plaintiff’s baby was larger than normal, and there were indications that the baby had shoulder dystocia. In the effort to dislodge the shoulder, the baby sustained injuries to his right arm, neck, and shoulder and suffered permanent neurological impairment and paralysis of the right arm. Thereafter, plaintiff Ramirez sued Gunter, McIntyre, and St. David’s for medical negligence. McIntyre moved for summary judgment as an affirmative defense under the Good Samaritan Statute, arguing that because there was no expectation of remuneration, he was within the scope of the statute and entitled to an absolute defense for his actions.
On review of the issue by the Texas Supreme Court, the high court held that summary judgment evidence conclusively established that McIntyre had not acted for or in expectation of remuneration because he had no duty to respond and the situation was emergent. Thus, he was entitled to a defense under the Good Samaritan Statute. **McIntyre v. Ramirez**, 109 S.W.2d 741 (Tex. 2003).

*Physician not liable under Good Samaritan Statute in an emergency situation because the physician did not have a duty to respond, and in responding had no expectation of remuneration.*

**Texas Supreme Court Refuses to Recognize Parents' Loss of Consortium Claim from Seriously Injured Child**
The day after her birth, infant plaintiff began suffering from severe acidosis, a condition that can cause heart and brain damage. Several hours later, after consulting with a neonatologist at another hospital, pediatrician Dr. Karen Roberts gave the infant sodium bicarbonate to counteract the acidosis. The infant sustained massive brain damage. Parent plaintiffs sued Roberts in state trial court, alleging a malfunctioning ventilator, the delay in administering sodium bicarbonate, and the failure to immediately transfer the infant to a better-equipped hospital proximately caused her injuries. The claims against Roberts proceeded to trial, which apportioned 15% of the responsibility for the injuries to Roberts. The jury awarded over $3 million in damages, including $75,000 to the parents for past loss of filial consortium.

The Texas Supreme Court declined to recognize a cause of action for a parent’s loss of consortium resulting from a non-fatal injury to a child. “We recognize the sympathetic and, on the surface, logical appeal to extending consortium rights to parents as well as children. But several states that have recognized a child’s right to loss of consortium have denied the parents any reciprocal right,” the majority’s opinion said. The high court explained that, in the parent-child relationship the child is the party needing special protection, not the parent. According to the high court, “no compelling social policy impels us to recognize a parent’s right to damages for the loss of filial consortium.” Thus, the high court reversed the judgment insofar as it awarded damages for loss of filial consortium but otherwise affirmed the award in all other respects. **Roberts v. Williamson**, 111 S.W.2d 113 (Tex. 2003).

*Texas does not recognize a common law cause of action for a parent’s loss of consortium resulting from a non-fatal injury to a child because, in the parent-child relationship, the child is the party needing special protection, not the parent.*
Vicarious Liability/Respondeat Superior

U.S. Court in New Hampshire Finds Hospital Not Vicariously Liable for Anesthetists’ Negligence Because Plaintiff Failed to Prove Hospital Vested Apparent Authority In Anesthetists

Dr. William Ural sought treatment for a back problem from Dr. Clifford Levy. Levy determined Ural needed spine surgery and suggested the surgery be performed at Concord Hospital. Anesthesia Associates’ employees Dr. Nichols and Dr. Sanborn provided anesthesia services during the surgery. Anesthesia Associates is an independent contractor that provides services to the hospital. Prior to surgery, Ural signed the hospital’s consent form, which included a provision that the providers were not employees of the hospital. During the operation, Ural suffered irreversible vision damage. Ural sued Levy, Nichols, Sanborn, and the hospital, claiming Nichols and Sanborn were agents of the hospital, and the hospital was vicariously liable under a theory of apparent authority. The hospital moved for summary judgment.

The U.S. District Court for the District of New Hampshire granted the hospital’s motion. Apparent authority may arise from acts or appearances of a principal that may lead a reasonably prudent person to believe there is an agency relationship between the principal and the alleged agent, said the court. The court determined Ural failed to present a genuine issue of material fact that the hospital had performed any act or maintained any appearances that would give a reasonably prudent person the impression that the hospital had vested apparent authority in Sanborn or Nichols. Ural’s only evidence of the alleged agency relationship was his unsupported assumption that there was an agency relationship, but the acts and appearances of the hospital did not support that assumption, said the court. The court also noted Levy testified that he probably told Ural the others were not employees of the hospital and Ural signed the consent form, which stated that the providers were not employees or agents of the hospital.


Apparent authority may arise from acts or appearances of a hospital that may lead a reasonably prudent person to believe there is an agency relationship between the hospital and the alleged agent.

Florida Appeals Court Holds Hospital Vicariously Liable for Negligence of Independent Contractor Based on Non-Delegable Contractual Duty

Two-month-old Gary Juliana II suffered severe brain damage following open-heart surgery at Shands Teaching Hospital and Clinic, Inc. (Shands). During the surgery, the operating room perfusionist, who runs the heart-lung machine used to oxygenate a patient’s blood, was negligent in monitoring Juliana’s blood gas levels. Shands has a contract with Cardiovascular Perfusionists, Inc. (CVP), which establishes the perfusionists supplied by CVP as independent contractors. Before the surgery, Juliana’s parents signed Shands’ admission form. The form obligated them to pay for “hospital care, [and] medical treatment,” which specifically excluded from its definition services provided by physicians, residents, and students as non-hospital employees.
Juliana’s parents (plaintiffs), sued Shands, alleging the hospital was vicariously liable for the perfusionist’s negligence as a matter of law. Plaintiffs moved for summary judgment. The trial court granted plaintiffs’ motion, holding that Shands was “clearly liable as a matter of law for the negligence of its sub-contractor.” Following a jury trial on damages only, the court entered a judgment against Shands for over $9 million. Shands appealed.

The Florida District Court of Appeal, First District, affirmed, finding no dispute of material fact existed under the theory of nondelegable duty on which the trial court relied. The appeals court noted that the perfusionist’s status as an independent contractor was irrelevant to the disposition of the case. The appeals court acknowledged the general rule that a hospital is not liable for the negligence of a physician who is an independent contractor, but emphasized that this rule does not apply with equal force to subcontractors like nurses or technologists who do not bill separately for their services. Nothing in Shands’ admission form advised plaintiffs that the perfusionist was not discharging the hospital’s duties under its contract with them, and the hospital billed plaintiffs for the perfusionist’s services.


A hospital cannot avoid vicarious liability for negligent performance of a nondelegable duty by subcontracting to a third party.

Missouri Appeals Court Holds Physician Was Neither Employee Nor Agent of Hospital at Time of Alleged Malpractice
In June 1997, Ronda A. Bost began obstetric treatment with Dr. Gordon B. Clark. On July 30, 1997, Clark terminated his employment with Lafayette Regional Health Center (LRHC) and Health Midwest. On October 19, 1997, Bost’s baby died during delivery at Western Missouri Medical Center (WMMC). Bost and her husband (appellants) sued LRHC, Health Midwest, and Clark for wrongful death, personal injury to Ronda, and loss of consortium. Appellants alleged medical malpractice by Clark for negligence in the delivery of the baby, and vicarious liability against LRHC and Health Midwest (respondents). Respondents moved for summary judgment, and the trial court sustained the motion. The trial court approved the wrongful death claims against Clark and dismissed the remaining claims against him. Appellants appealed.

The Missouri Court of Appeals affirmed. The appeals court first found that respondents supported their claim that Clark was not an employee or agent in October 1997 by providing a copy of a release and settlement between them and Clark from July 1997, in which Clark’s employment was terminated. Appellants argued in the alternative that, if Clark was not an employee, he was an actual agent. For reasons similar to those above, the appeals court held that Clark was not an agent of respondents. The appeals court then addressed the wrongful death and personal injury claims based on Clark allegedly acting as an apparent agent of respondents. The appeals court explained that apparent agency is established by acts that lead a person to believe the apparent agent has been given authority to act by the apparent
principal. In this case, appellants were claiming they needed discovery of the documents to determine if they relied on Clark’s apparent authority. Therefore, the production of the requested documents would not have changed the outcome of the summary judgment motion. **Bost v. Clark**, 116 S.W.3d 667 (Mo. Ct. App. 2003).

*A hospital is not liable for the actions of a physician who is neither an employee nor agent of the hospital at the time of the alleged negligence.*

**Kentucky Appeals Court Says Plaintiffs Raised Genuine Issue of Fact Whether Physician Was Employee or Independent Contractor of Hospital**

Plaintiffs took their infant son to Tri-County Baptist Hospital because he was constantly crying, stiff, and rigid. Dr. Plavakeerthi Kemparajurs, the infant’s primary care physician, was contacted and would not authorize payment of insurance for treatment. Dr. Richard Lawrence examined the infant, diagnosed colic, and sent him home. The infant died of a seizure disorder two days later. Plaintiffs sued the hospital and Kemparajurs (defendants) for wrongful death based on the actions of Lawrence and a nurse, although neither Lawrence nor the nurse was named in the suit. The hospital moved for partial summary judgment, claiming Lawrence was an independent contractor. Following a trial, defendants moved for a directed verdict, which the trial court granted on the ground there was insufficient evidence of causation, but the trial court failed to address the issue of Lawrence’s status. Plaintiffs appealed. The appeals court affirmed the verdict for Kemparajurs and for the hospital on the issue of liability for Martin’s acts, but remanded for a new trial on the issue of Lawrence’s actions in failing to evaluate the infant. The hospital moved for summary judgment again on the grounds Lawrence was an independent contractor. The trial court found the contract provisions showed that Lawrence was an independent contractor, and granted the summary judgment motion against plaintiffs. Plaintiffs appealed.

The Kentucky Appeals Court vacated the trial court’s judgment on the ground there was a question of fact about whether Lawrence was an agent of the hospital. The appeals court said the trial court erred in finding the agreement did not give the hospital any control over Lawrence because the plain language of the agreement showed that the hospital retained control over him in several significant ways, including that the hospital retained ultimate control over Lawrence’s ability to practice medicine in the hospital. The court found the agreement appeared to be nothing more than an attempt to evade the “doctrine of respondeat superior while actually enjoying the benefits of an employer/employee relationship.” **Shofner v. Baptist Healthcare Affiliates, Inc.**, No. 2002-CA-001637-MR, 2003 WL 22025906 (Ky. Ct. App. Aug. 29, 2003).

*A hospital does not automatically avoid the doctrine of respondeat superior by representing independent contractor status in contractual agreements if significant control is retained over the contractor.*
Mississippi Appeals Court Says Physicians Were Not Independent Contractors and Sovereign Immunity Applied to Their Actions

Plaintiff was treated for chest pain by a cardiovascular surgeon at the University of Mississippi Medical Center (UMMC). The surgeon diagnosed acute heart disease and prescribed medication, but when plaintiff’s condition worsened, physician performed heart bypass surgery. The surgeon referred plaintiff to a second physician, a hematologist, several days after surgery because plaintiff had an abnormal decrease in blood platelets. The hematologist diagnosed plaintiff with thrombocytopenia, which was caused by a medication prescribed by cardiovascular surgeon. As a result of the thrombocytopenia, plaintiff’s legs had to amputated. Plaintiff sued the physicians on a claim of medical malpractice. The physicians each responded by claiming the affirmative defense of sovereign immunity as employees of the UMMC.

The Mississippi Court of Appeals affirmed the trial court’s dismissal based on sovereign immunity after applying a five-factor test to determine whether physicians were employees or independent contractors for purpose of sovereign immunity. These five factors included (1) the nature of the function performed by employee, (2) the extent of the state’s interest and involvement in the function, (3) the degree of control and direction exercised by the state over the employee, (4) whether the act complained of involved the use of judgment and discretion, and (5) whether the physicians received compensation, either directly or indirectly, from the patient for professional services rendered. Weighing all of these factors, the appeals court concluded that physicians were employees of UMMC while they were treating plaintiff. Brown v. Warren, 858 So.2d 168 (Miss. Ct. App. 2003).

Physicians were employees of state university based upon a five-factor test.

Florida Appeals Court Finds Question of Fact as to Hospital’s Vicarious Liability for Radiologist’s Alleged Negligence as Apparent Agent

Plaintiff was admitted to defendant hospital through its emergency room after physicians detected a life-threatening condition requiring immediate surgery. While an inpatient at the hospital, plaintiff was taken to hospital’s radiology department for scans of his abdomen. Defendant radiologist interpreted the scans. Defendant was an employee of a radiology group that contracted with the hospital to be the exclusive provider of radiology services. Following surgery, plaintiff suffered numerous complications, requiring him to stay in the hospital for over two months.

Plaintiff sued the hospital for medical malpractice based on a theory of vicarious liability for the radiologist’s alleged medical malpractice. According to plaintiff, defendant radiologist had misinterpreted the scan. Plaintiff also alleged that defendant radiologist was an agent of hospital and that the negligence occurred while he was serving in that capacity. The Florida District Court of Appeal reversed the trial court’s grant of summary judgment, stating that questions of fact on the issue of whether the hospital could be held vicariously liable for defendant radiologist acts under a theory of apparent agency existed. Roessler v. Novak, 858 So.2d 1158 (Fla. Dist. Ct. App. 2003).
The question of a physician’s apparent authority to act for a hospital is usually a question of fact for the jury and defeats a granting of summary judgment.

Kentucky Appeals Court Says Hospital Was Not Liable for Wrongful Death Because Physician Was Independent Contractor

Plaintiff sued defendant physician and the hospital following the death of his father after complications from surgery. Five years after the suit was filed, plaintiff discovered that defendant pathologist had misread tissue specimens from the decedent, and defendant surgeons claimed that if they had known the correct results they would have provided a different treatment for decedent. Defendant pathologist moved to dismiss, arguing the complaint was not timely based on a one-year statute of limitations, which the trial court granted. Additionally, the trial court granted defendant hospital’s motion to dismiss on the grounds that defendant pathologist was an independent contractor and not an employee of defendant hospital.

The Kentucky Court of Appeals affirmed the trial court’s finding that the defendant pathologist was an independent contractor based on the relevant factors for determining if a person is an employee or independent contractor. Specifically, the appeals court noted that (1) defendant pathologist is in a highly specialized practice area that usually has no supervision, (2) defendant pathologist bills patients directly, (3) defendant pathologist’s contract with the hospital suggests that both parties believed he was an independent contractor, and (4) most importantly, defendant hospital had minimal control over the details of defendant pathologist’s work.


California Appeals Court Says Clinic Owner Failed to Show She Was Not Responsible for Acts of Clinic’s Agent

Plaintiff went to defendant clinic to have a tattoo on her leg removed by laser surgery. Plaintiff met with defendant physician, who agreed to remove the tattoo. Defendant physician attempted to remove the tattoo with a laser he knew was not the proper tool. Defendant physician had never before attempted to remove a tattoo through laser surgery. Plaintiff suffered severe burns during the procedure and later had to undergo surgery and skin graphs.

The California Court of Appeal affirmed the trial court’s judgment of liability and compensatory damages against physician, but reversed and remanded on the issue of whether the clinic was liable for physician’s actions. The appeals court found ample evidence to reject the claim that the clinic did not have control over physician’s conduct because the clinic failed to present evidence to support the contention that physician was an independent contractor. The appeals court held that a subjective belief that a person did not really own a business and was not liable for the actions within that business is not enough to evade liability for any acts by agents of the business.
A subjective belief that a person did not really own a business is not enough to evade liability for acts by agents of the business.

Georgia Appeals Court Says Summary Judgment Was Improper Because Issue of Fact Existed Whether Physician Was Employee or Independent Contractor

An emergency room physician treated plaintiff and diagnosed him with a transient ischemic attack, but did not prescribe a blood thinner. Plaintiff returned home and suffered an incapacitating stroke the next day. Plaintiff sued the physician and the hospital for medical malpractice. The trial court granted summary judgment in favor of the hospital based on its finding that the physician was an independent contractor.

The Court of Appeals of Georgia reversed, finding a genuine issue of fact whether the physician was an actual or apparent employee of the hospital. The appeals court opined that the hospital is liable for the negligent actions of its employees, but noted that merely being on the medical staff of the hospital is not dispositive of a physician’s status. The appeals court explained that a hospital could also be liable for the negligent actions of an independent contractor if the hospital retains control over the contractor. The appeals court identified several factors to consider in determining whether a physician is an employee or an independent contractor and noted that, in the instant case, the hospital controlled the physician’s work, the work was indicative of an employee-employer relationship, the hospital controlled the hours the physician worked, and the physician had no right to designate his hours of availability. Moreover, the physician had no separate medical practice, and the hospital paid the physician’s medical malpractice insurance premiums. Based on such facts, the appeals court found sufficient evidence to support a finding that the physician was an employee of the hospital and, therefore, the trial court erred in granting summary judgment.


Summary judgment is improper if an issue of fact exists for the jury to consider concerning whether the physician was an employee or an independent contractor. Labeling a physician as an independent contractor or an employee is not determinative the physician status and will not shield the institution from liability.

Kentucky Appeals Court Says Physician Was Independent Contractor Because Hospital Did Not Exercise Control Over Physician

An emergency room physician treated an infant boy for hand lacerations that turned out to be more severe than first known. After the boy suffered three severed tendons and nerve damage, his parent sued the emergency room physician, the pediatrician who followed up on the care, and the hospital. The trial court granted summary judgment in favor of the hospital on the grounds that the emergency room physician was an independent contractor.
The Kentucky Court of Appeals affirmed. In so holding, the appeals court stated that, in order to determine whether a person was an independent contractor or an employee, a court must consider the nine factors set forth in § 220(2) of the Restatement of the Law of Agency. The court rejected plaintiff’s argument of ostensible agency because the medical authorization form signed on admission by boy’s father stated that the physicians were independent contractors, not employees or agents of the hospital. Finally, the court concluded “that a party who can read and has an opportunity to read the contract which he signs must stand by the words of the contract unless he is misled as to the nature of the writing which he signs or his signature is obtained by fraud.”


A court must consider the nine factors set forth in § 220(2) of the Restatement of the Law of Agency when determining whether a person was an independent contractor or an employee. Hospitals must also examine the same nine factors to ensure that they are correctly categorizing their physician relationships.

**Elements of Claims**

**Connecticut Appeals Court Says Psychiatrist and Psychologist Did Not Owe Duty of Care to Decedent Who Was Killed When Patient Fell Asleep While Driving After Taking Prescription Medication**

Plaintiff’s wife was killed in a motor vehicle accident in which she was struck head-on by the motor vehicle operated by an individual who had fallen asleep at the steering wheel as a result of side effects from the medicine prescribed by a psychiatrist and a psychologist (collectively “defendants”). The trial court granted defendants’ motion for summary judgment, stating that defendants did not owe the decedent any duty of care because there was no patient-physician relationship.

Affirming the trial court’s decision, the Connecticut Court of Appeals concluded, “the issue in this wrongful death action is whether a psychiatrist and a psychologist have a duty to warn their patient not to operate a motor vehicle after ingesting prescribed medication. We conclude, as a matter of law, under the facts of this case, that the defendants had no duty to warn the patient not to operate her motor vehicle for the benefit of the decedent and, therefore, affirm the judgment of the trial court.”


*Physicians do not owe duty of care if there is no patient-physician relationship.*

**Louisiana Appeals Court Says Res Ipsa Loquitur Could Apply Because Material Issue of Fact Existed About How Plaintiff Was Injured**

In November 1999, plaintiff underwent surgery performed by one physician and anesthesia administered by another physician. Plaintiff later consulted a third physician complaining of respiratory problems. A chest x-ray was taken and revealed a tooth lodged in plaintiff’s lung. Plaintiff sued the physician who performed the
surgery and the anesthesiologist who administered the anesthesia (collectively “defendants”). Defendants moved for summary judgment, arguing that plaintiff did not meet the burden of proof by providing expert testimony to support the claim that defendants had failed to meet the applicable standard of care. Plaintiff argued that expert testimony was not required based on a theory of res ipsa loquitur. Plaintiff supported the argument with an affidavit from a dentist stating that the most plausible explanation for the injury was that the tooth became dislodged during the surgery. The trial court granted defendants’ summary judgment motion.

The Louisiana Court of Appeals reversed, concluding that the res ipsa loquitur doctrine was applicable to plaintiff’s allegation that his injury arose as result of inadequate care provided by surgery staff and anesthesiologist.  

*Where there is evidence to determine reasonable cause, the doctrine of res ipsa loquitur applies.*

**Indiana Appeals Court Says Summary Judgment Was Improper Because Expert Affidavit And Deposition Testimony Conflicted and Raised Issue of Fact**

Plaintiff was involved in an auto accident and was transported in an ambulance to the nearest hospital. Plaintiff was later transported to another hospital for surgery to repair injuries. Plaintiff sued the ambulance company for failing to improperly designating plaintiff for basic life support, requiring an emergency medical technician, as opposed to an advanced life support designation, requiring a paramedic to accompany the ambulance run. Plaintiff appealed the trial court’s summary judgment order in favor of defendant.

The Court of Appeals of Indiana reversed. The appeals court found that the presence of the conflicting statements in the ambulance company’s medical director’s deposition, coupled with the submission of an affidavit of a paramedic stating that the ambulance company’s treatment of the plaintiff fell below the standard of care, was sufficient evidence of genuine issues of fact of whether the assessment and the transport were proper.  

*Where there is a conflict in the evidence presented and/or the testimony, there is a genuine issue of fact and summary judgment is improper.*

**New Jersey Supreme Court Reinstates Jury Verdict in Malpractice Case, Holds Plaintiff Provided Sufficient Evidence That Defendant’s Actions Were Substantial Factor in Harm to Patient**

Between May 1993 and July 1994, plaintiff took her 17-year-old son to defendant physician because her son repeatedly complained of experiencing lethargy, leg pain, and intestinal problems. In July 1994, plaintiff obtained a referral to take her son to a
specialist, who diagnosed the son with a malignant tumor in his leg. Plaintiff’s son underwent surgery to remove the tumor, but it had metastasized to his lungs and he died in May 1995. Plaintiff filed a malpractice action based on the delayed diagnosis of a malignant cancerous tumor. The jury awarded $8 million, which was reduced to $4.4 million. The trial court then agreed to issue a judgment notwithstanding the verdict because plaintiff had failed to prove causation. The appeals court agreed, and plaintiff appealed to the state’s high court.

The New Jersey Supreme Court reversed and reinstated the jury’s verdict. The high court stated that, because the facts were for a pre-existing condition, actual causation was only a substantial factor, not a requirement. The high court determined that plaintiff had proved earlier detection of the cancer would have increased her son’s chance of survival. *Verdicchio v. Ricca*, 843 A.2d 1042 (N.J. 2004).

*Plaintiff needed to show only that the doctor’s oversight increased the risk of losing the chance for earlier treatment.*

**Mississippi Appeals Court Says Physician Did Not Breach Duty of Care to Inform Patient of Surgery Risks**

Plaintiff, experiencing a history of back pain and degeneration of the discs in the spine, agreed to have back surgery as recommended by defendant. Plaintiff signed the surgical consent form, which contained an acknowledgement that defendant had explained the risks of the surgery to plaintiff. After surgery, a hematoma developed and was later removed, causing plaintiff permanent nerve damage that affected his legs. Plaintiff filed a medical malpractice action, alleging defendant was negligent and failed to meet the minimum standard of care with regard to informed consent for surgical treatment. The trial court granted summary judgment to defendant. Plaintiff appealed, asserting that there was a factual dispute concerning whether defendant gave any warnings at all and whether the warnings, if any, met the applicable standard of care.

The Mississippi Court of Appeals affirmed the trial court’s judgment on grounds that defendant did not breach the duty to inform. The appeals court opined that, in order to prove breach of the duty to inform, plaintiff must not only allege defendant did not obtain consent, but also must show that a reasonable patient would have withheld consent if properly informed of the risks that the treatment made the condition worse. The appeals court found evidence that plaintiff was adequately informed of the risks of and consented to surgery, and plaintiff failed to provide evidence to the contrary. *Barton v. Estate of Buckley*, 867 So.2d 271 (Miss. Ct. App. 2004).

*To prove breach of the duty to inform, a plaintiff must allege that defendant did not obtain consent and show that a reasonable patient would have withheld consent if properly informed of the risks that the treatment made the condition worse.*
Defenses

Iowa Supreme Court Says Statute of Limitations Began to Run from Date Patient Knew or Should Have Known of Injury, Not Date Patient Discovered Surgery Was Unnecessary

Plaintiff was diagnosed with throat cancer and told by defendant that his voice box needed to be removed to save his life. Defendant did not inform plaintiff of less radical non-surgical options, such as radiation, or less radical surgical options. Later Plaintiff learned that defendant had been removed from practice because of narcotics addiction. Plaintiff submitted his medical records to the Iowa Board of Medical Examiners (Board). The Board suspended defendant’s license to practice medicine on grounds that defendant performed excessive surgery. Plaintiff sued defendant, claiming that the surgery was unnecessary and excessive. Defendant moved for summary judgment based on the two-year statute of limitations for medical malpractice because plaintiff did not file the lawsuit until more than two years after the surgery. The court denied the motion, and defendant appealed.

The Iowa Supreme Court reversed, explaining that the statute establishes knowledge of injury, not knowledge of the wrongful act, as the date that the limitations period begins to run. The high court further determined that the wrongfulness of the act is a necessary component to acquiring knowledge of the injury, explaining that the voice box’s removal, as the intended result, cannot, by itself, be viewed an injury by plaintiff. The high court noted that patient did not know he had been injured until discovering the procedure may have been unnecessary, and emphasized that the fact this information also provided knowledge of a wrongful act did not take away its value as evidence of knowledge of injury.


In Iowa, the statute of limitation begins to run from the time of any known or, through reasonable diligence should have known, injury.

Discovery, Evidentiary, and Trial Practice Issues

New Jersey Appeals Court Says Judge Must Weigh Probative Value of Invasive Medical Procedure Against Potential Risk to Plaintiff Before Ordering Independent Medical Exam

During a c-section, defendant physician incised plaintiff’s cervix and bladder instead her uterus. Several months later, plaintiff complained of inadequate bladder capacity and painful urination, and underwent a cystoscopy and urodynamic study. Plaintiff had difficulty with the procedure and had to be placed under general anesthesia to complete the study. Plaintiff sued defendant, and defendant asked that plaintiff undergo an independent medical examination that would include a repeat cystoscopy and urodynamic study. The trial judge did not compel plaintiff to undergo the testing but ruled that, if she refused, she could not make a claim for damages based on her alleged bladder dysfunction and urinary tract complications.
The New Jersey Court of Appeals held that the trial court judge failed to engage in the appropriate balancing process when weighing the probative value of the exam against the potential risks and discomfort to plaintiff and that to completely bar plaintiff’s action was an extreme sanction to be reserved for only exceptional cases. The appeals court explained that, to determine whether good cause exists to order a party to submit to an invasive medical examination, a judge must engage in a fact-sensitive, risk-benefit analysis weighing the potential harm and risk to the objecting party against the requesting party’s need, as well as consider equity and fairness concerns. The relevant factors include whether defendant can obtain the information in other ways, whether plaintiff had undergone a similar examination, whether the examination is necessary to determine the extent of plaintiff’s injuries, and whether plaintiff’s refusal to undergo the procedure is reasonable in light of the examination’s potential risks and resulting harm.


*A court may order a plaintiff in a medical malpractice action to undergo an invasive medical malpractice procedure at the defendant’s request if the probative value of the exam outweighs the potential risks and discomfort to the plaintiff.*

**Damages Elements**

**Florida Supreme Court Says Wrongful Death Act’s Limitation on Recovery for Economic Damages Does Not Apply to Action Brought Under Medical Malpractice Act**

Plaintiff, who sued defendant medical center for her husband’s wrongful death, agreed to proceed under the alternative arbitration procedure of the Medical Malpractice Act (MMA). The arbitration panel awarded plaintiff economic damages but nothing for loss of social security benefits. The Florida Court of Appeals, First District, affirmed the arbitration panel’s decision and held that the plaintiff failed “to show not only a fall in household income, but also that lower expenses did not offset the drop.”

The Florida Supreme Court held that the appeals court erred in relying on the concept of “net accumulations” and remanded the case for a re-determination of the value of the lost social security benefits. The high court opined that the MMA allows the award of a full range of economic damages, while the Wrongful Death Act (WDA) limits recovery of economic damages. In *Chester v. Doig*, 842 So.2d 106 (Fla. 2003), the high court held that the damages provisions of the MMA applies to any malpractice action including those involving wrongful death, and the WDA does not control on the issue of damages because there is no specific provision in the MMA for such application of the WDA. Consequently, the high court held that the correct calculation for plaintiff’s economic damages for the loss of the social security benefits was the difference between the amount the plaintiff and her husband received before his death and the amount plaintiff currently received. The dissent disagreed with the majority’s interpretation of the MMA and opined that the MMA should be interpreted in conjunction with the WDA.

When determining economic damages in a medical malpractice action for wrongful death, a claimant is entitled to the full economic damages subject to only two reductions: (1) claimant is entitled to only 80% of the wage loss and loss of earning capacity and (2) an offset for certain collateral sources of income.

IV. MEDICAL RECORDS

Illinois Appeals Court Holds Provider Had to Furnish Information to State Department for Peer Review

The Illinois Department of Public Aid (Department), through the Bureau of Medical Quality Assurance (Bureau), requested that Dr. Suresh Chand produce patient medical charts as part of a peer review to determine his compliance with Department policies. Chand refused, alleging the Department had not complied with the Mental Health and Developmental Disabilities Confidentiality Act (Act). Chand’s eligibility with the Department was terminated. Chand sought judicial review, and the trial court continued the proceedings because of a pending separate appeal about issues raised in this case between the Department and Chand. The appellate court affirmed the Department’s termination of Chand as a vendor because his medical services were harmful and grossly inferior. The Illinois Supreme Court denied Chand’s appeal.

Following the resolution of the appeal, the trial court held that the case was not moot because the Department’s regulations requiring disclosure of the patient records without the patient’s consent violated the Act. The trial court also held Chand’s failure to complete the physician’s questionnaire was not a sufficient ground for termination. The Illinois Appellate Court affirmed in part and reversed in part. Noting an exception to the mootness doctrine for collateral legal consequences, the court said the order terminating Chand’s eligibility could be used against him when he applies for reinstatement. The court found the request for records was properly made under the Act, but disagreed that Chand had to tell recipients their records might be released, noting that the Act does not require such disclosure because it could affect the confidential relationship of a provider and patient. The Department is required to limit its request for records, said the court, and inform a recipient of the disclosure. The appeals court held the Department failed to prove the recipients had been previously informed of the disclosure and the procedures used to obtain the patient information violated the Act. The appeals court determined Chand had failed to provide a questionnaire that the Department had properly requested, and the requested information was directly related to his rendering of services to recipients. Therefore, the appeals court held the trial court had erred and it reversed the judgment on that issue. The appeals court remanded the case for the trial court to determine the appropriate attorneys’ fees on the medical records issue.

Physician credentialing materials are subject to disclosure to a state medical program for peer review purposes.

Indiana Appeals Court Says Social Worker/Client Privilege Applies Retroactively to Communications Made Before Enactment of Privilege Statute
In 1988 and 1989, the Pelley family attended counseling sessions at the Family and Children Center on at least twelve occasions. In April 1998, the Pelley parents and their two daughters were murdered in their home. In 2002, the Pelley son was charged with four counts of murder, and the state issued a subpoena to the Center for its records of the counseling sessions. The Center moved to quash the subpoena on the ground that the social worker/client privilege applied, and that the communications did not fall within the homicide exception. The state argued the social worker/client privilege did not apply retroactively because it became effective in July 1990.

The Indiana Court of Appeals affirmed the trial court’s judgment, agreeing to quash the subpoena following a hearing and in camera review of the documents. The appeals court held that, once the social worker/client privileges statute became effective, it covered discovery requests after that date, and the Center did not have to disclose the communications. The appeals court then found that no legislative history indicated that the statute was meant to be applied retroactively. The appeals court did find that a close temporal proximity of a court’s decision on the same subject matter and the enactment of the statute made it reasonable to conclude that the statute was intended to be remedial. Therefore, because the statute was remedial, it could be applied retroactively.


*A privilege statute can be applied retroactively as long as there is sufficient evidence indicating that the statute is meant to be remedial.*

V. PROFESSIONAL RIGHTS

 Maryland Appeals Court Affirms Revocation of Physician’s License in Case in Which Sexual Relationships with Patients Took Place During Medical Treatment
In October 1998, the Board of Physician Quality Assurance for the State of Maryland (Board) received a complaint from one of Dr. Thomas Finucan’s patients that he had engaged in a sexual relationship with her while acting as her physician. After an investigation of the complaint, the Board determined that, from 1993 through 1998, Finucan had engaged in sexual relationships with several patients while maintaining a physician/patient relationship with them. The Board thus charged him with immoral and unprofessional conduct. At an administrative hearing, Finucan admitted that he had sexual relationships with two of the patients but only after they were no longer patients. After the hearing, the administrative law judge issued a revised decision finding sufficient evidence that Finucan had engaged in sexual relationships with three patients over a period of years, and that he had exploited the physician/patient relationship.
relationship. The Board issued a final order adopting the ALJ’s decision. Finucan filed for a judicial review of the Board’s order, which the trial court affirmed.

The Maryland Court of Special Appeals affirmed the decision of the Board after concluding that the sexual relationships grew out of a physician/patient relationship, that Finucan had exploited the trust that his patients had in him, that Finucan lost objectivity in the treatment of those patients, and that Finucan damaged the patients emotionally because two of the patients sought therapy after their relationships with him ended. As a result of all of those factors, the appeals court concluded that Finucan’s sexual relationship with the patients arose out of and was connected with his medical treatment with the patients.


Revocation of a physician’s license is proper in case in which the physician engaged in sexual relationships with patients during the course of medical treatment, which resulted in damage to patients as evidenced by subsequent therapy.

**Medical Groups Policy of Terminating Its Professional Relationship with Patients who Sued for Malpractice Does Not Violate Anti-Discrimination and Unfair Competition Laws.**

Plaintiffs contracted for medical insurance with Health Net, choosing Scripps Clinic as their medical group. Subsequently, plaintiffs sued two Scripps physicians for medical malpractice. Thereafter, Scripps asked Health Net to terminate Scripps as plaintiffs’ medical group, citing their medical malpractice action. Plaintiffs sued Scripps in state court, arguing that Scripps’ policy of terminating care for patients who file lawsuits against the group is illegal. Plaintiffs’ claims included allegations of tortious interference with contractual relations, violation of the Unruh Act, breach of public policy, and violation of the Cartwright Act. The court denied defendant’s summary judgment motion.

The California Court of Appeal held that retaliatory discrimination against patient litigants does not violate the Unruh Act, which prohibits discrimination based on characteristics such as sex, race, and religion. The appeals court observed that defendant has a legitimate business interest in excluding patient litigants to preserve the physician-patient relationship, and the policy was universally applied to all patients who filed claims against the practice group. The appeals court also found no violation of the Cartwright Act. Importantly, the court noted that, where the purpose of the defendant’s policy was not to produce any of the prohibited anti-competitive effects contemplated by the Cartwright Act, and where there was no resulting restraint on trade, there was no violation of the Act. Finally, the appeals court held that defendant had not engaged in unfair competition or violated public policy because a physician has a lawful right to withdraw from treating a patient after notice and a reasonable time to secure another physician.

A medical group’s policy of terminating professional relationships with patients who file malpractice actions against the group does not violate anti-discrimination and unfair competition laws where the policy is uniformly applied.

Sixth Circuit Says Hospital Board That Revoked Physician’s Medical Staff Privileges Is Entitled to HCQIA Immunity
Logan Memorial Hospital, Inc.’s (LMH) board of trustees (Board) appointed Dr. Robert Meyers to its medical staff in 1991. Following a subsequent reevaluation, the Board panel conducted a review of concerns about Meyers’ behavior, inability to get along with others, and surgical technique. In March 1994, the panel voted to deny Meyers’ appointment to active staff. The Board then initiated fair hearing procedures, during which Meyers was given the opportunity to present evidence and examine witnesses. The fair hearing committee recommended that LMH not appoint Meyers to its staff. Meyers appealed, but the Board eventually decided to revoke his privileges. Meyers sued in state trial court, seeking the reinstatement of his staff privileges. Meyers also filed a second suit in state trial court against multiple defendants. Meyers also filed a third action in federal court against twenty-two defendants, including hospital administrators and several Board members. The district court granted summary judgment in defendants’ favor based on Health Care Quality Improvement Act (HCQIA) immunity. Meyers appealed.

The Sixth Circuit affirmed. First, the appeals court found the district court properly granted summary judgment on the basis of HCQIA immunity, which creates a rebuttable presumption of immunity for professional review actions. The appeals court found Meyers failed to raise a genuine issue of material fact as to any of the four statutory elements required for HCQIA immunity: (1) the action was in furtherance of quality healthcare, (2) the action was taken after a reasonable effort to obtain the facts of the matter, (3) Meyers received adequate notice and hearing procedures and (4) the action was taken in the reasonable belief that the action was warranted by the facts. The appeals court rejected Meyers’ argument that HCQIA immunity did not apply because the review was conducted entirely by nonmedical personnel. Meyers v. Columbia/HCA Healthcare Corp., 341 F.3d 461 (6th Cir. 2003).

The protections afforded under HCQIA for professional review actions extend to all participants in the process, including non-physicians.

California Supreme Court Holds Hospital’s Response to Inquiry About Physician Was Entitled to Qualified, Not Absolute, Privilege
After Dr. Allen Hassan applied for staff privileges at Roseville Community Hospital (Roseville), Roseville’s credentials committee wrote to Mercy American River Hospital (Mercy), where Hassan had privileges from 1970 to 1986, asking for information. Because the facility where Hassan did his residency from 1967 to 1970 was no longer operating, the chairman also asked Mercy for any information they had regarding Hassan’s work at that facility. Mercy provided a chronology of Hassan’s years at Mercy and attached copies of letters regarding his prior residency at Mendocino State
Hospital (Mendocino), including a memorandum of a phone conversation between Mercy’s medical director, Dr. Ralph S. Jensen, and Mendocino’s associate medical director. The memorandum described Hassan as “‘MILITANT’ vs. authority . . . [t]ends to identify with the underdog . . . might be desirable in general medicine but not with mentally disturbed.” Roseville denied Hassan’s application for privileges, but eventually admitted him as an active physician with limited privileges. Hassan sued Mercy in state trial court for defamation, intentional interference with prospective business advantage, and negligent interference with economic relationship. Hassan also asserted that Mercy acted with malice in sending the memorandum to Roseville. Mercy moved for summary judgment, claiming statutory privilege. The trial court granted the motion. Hassan appealed, and the appeals court affirmed. Hassan appealed.

The California Supreme Court affirmed. First, the high court held that the language “any person” as used in the relevant statute included entities like Mercy. Next, the high court concluded that communications protected by the statute are entitled to qualified, not absolute, privilege. Thus, the high court continued, a plaintiff may defeat a privilege claim by showing “the communicator knew the information was false or otherwise lacked a good faith intent to aid in the evaluation of the practitioner.” Finding no legislative intent that § 43.8 afforded an absolute privilege that would immunize the communication of knowingly false and defamatory statements about a medical practitioner, the high court affirmed the appeals court’s judgment. Hassan v. Mercy Am. River Hosp., 74 P.3d 726 (Cal. 2003).

The peer review protections afforded to individuals and entities are qualified and will not protect communications made with malice.

Illinois Appeals Court Holds Peer Review Documents Are Privileged

In November 1999, plaintiff underwent surgery at Northwest Community Hospital, Inc. (Northwest), and later developed complications that had to be surgically repaired. During the second surgery, plaintiff aspirated vomit and developed aspiration pneumonia. Plaintiff sued for negligence. During discovery, plaintiff requested documents relating to the peer review process at Northwest. Northwest objected and filed a privilege log and the documents as ordered by the trial court for in camera review. The trial court held all the material Northwest claimed was privileged was discoverable. because Northwest failed to establish when the peer review process started and ended in this case. Northwest moved for reconsideration and in support filed two affidavits by members of its quality measure and improvement department outlining the peer review process for plaintiff’s case. The trial court denied the motion. Northwest refused to produce the documents, and the trial court held Northwest in contempt. Northwest appealed.

The Illinois Court of Appeals held the trial court abused its discretion in allowing discovery of the documents, reversed the contempt ruling, and remanded the case. The appeals court agreed that the results of a peer review process are not privileged, but said the trial court erred in giving a broad interpretation of what it considered...
“results.” The appeals court noted the trial court did not initially request documentation of the temporal limitations. Finding the trial court erred in not requesting the documentation earlier, the appeals court determined Northwest was entitled to file the affidavits supporting its establishment of the temporal limitations. Following a review of the disputed documents, the appeals court concluded the documents were privileged because they were an integral part of the peer review process and were not discoverable.


A hospital is entitled to file support affidavits to establish the temporal limits of the peer review process.

**U.S. Court In Louisiana Finds No Federal Medical Peer Review Privilege**

Plaintiff physician sued defendant hospital after her medical staff privileges at the hospital were reduced to courtesy privileges. As part of discovery, plaintiff served a subpoena for production of hospital peer review files on all other cardiologists with staff privileges. Defendant moved to quash plaintiff’s subpoena, arguing that the requested peer review files were privileged.

The U.S. District Court for the Eastern District of Louisiana refused to recognize a federal privilege for medical peer review documents sought by a physician claiming that a hospital violated her due process rights when it reduced her medical staff privileges. The court found no indication in federal common law or the Health Care Quality Improvement Act that a federal statutory medical peer review privilege was established. The court concluded that the documents should be produced, explaining that the case involved federal claims and neither the U.S. Supreme Court nor other federal courts have found such privilege in the medical peer review context. The magistrate judge did issue a protective order to keep the information at issue confidential in recognition of the fact that there is no federal medical peer review confidentiality statute.


_Federal courts have declined to establish a federal law privilege for peer review materials and have found specifically that no such privilege in the medical peer review context exists._

**Texas Appeals Court Says Privileges Do Not Apply to Documents Already Produced in Response to Discovery Request**

Plaintiff sued defendant nursing home, claiming plaintiff had received negligent medical care while a resident of the facility. During discovery, plaintiff requested the production of personnel files and other related documents for all nursing personnel and administrators of the nursing home, and documents relating to patient care. Defendant objected to the request of documents related to patient care, arguing that they were protected by physician/patient privilege, and to the request of personnel files, arguing that they were protected by medical peer review privilege, medical
committee privilege, and nursing peer review privilege. The court denied defendant’s motion.

The Texas Court of Appeals concluded that, because defendant produced the personnel files, failed to timely raise the issue of privilege, and failed to respond to plaintiff’s claim of waiver, the trial court had not erred in concluding defendant nursing home’s production of the fifty one personnel files was an implicit waiver. Additionally, the court concluded that defendant had failed to meet its burden of showing the patient care documents fell within the physician/patient privilege because defendant failed to disclose what information was in such documents and how the information came within the privilege.


Peer review privilege does not apply to documents already produced in response to discovery requests.

New Jersey Appeals Court Says Purely Factual Material in Peer Review Committee Report Was Discoverable, But Deliberative Information Was Not

Plaintiff sought discovery of the peer review committee report about plaintiff’s case because there were factual discrepancies regarding how plaintiff’s treatment proceeded and missing x-rays. The trial court granted plaintiff’s motion to compel production.

The New Jersey Superior Court, Appellate Division, affirming in part and reversing in part, held that some parts of the peer report could be disclosed and other parts were privileged. In performing the balancing test set forth in *Payton v. New Jersey Turnpike Auth.*, 691 A.2d 321 (N.J. 1997), the appeals court held that the factual information contained in the peer review report could be disclosed to plaintiff because plaintiff’s interest in obtaining factual information outweighed defendant’s interest in keeping the information confidential. The appeals court also held that the portions of the peer review report that evidenced the peer review committee’s deliberative process, including opinions, were confidential and not subject to disclosure.


Factual material in peer review committee reports is discoverable. Deliberative information contained in the peer review committee reports, including opinions, are not subject to disclosure.

Kentucky Appeals Court Rules Physician Was Under Investigation for Purposes of HCQIA Reporting Requirement

Hospital staff raised quality concerns about physician, which prompted the hospital’s quality assessment and improvement committee (Committee) to review five of the physician’s cases. The Committee found major quality of care concerns and forwarded such concerns to the medical executive committee (MEC). Following additional ad hoc proceedings, the MEC decided to review and supervise the
physician’s practice. Before a report by the outside reviewer could be presented to the MEC, the physician resigned and sought an injunction to enjoin the hospital from submitting a report to the state medical board and National Practitioner Data Bank regarding physician’s resignation pursuant to the Health Care Quality Improvement Act (HCQIA). The trial court granted summary judgment for the hospital and dismissed plaintiff's suit.

The Kentucky Court of Appeals, affirming the trial court’s decision to refuse physician’s attempt to enjoin the hospital from filing a HCQIA report, held that the physician resigned from the hospital while he was clearly “under investigation” for quality of care issues, thus triggering the reporting requirement under HCQIA. *Omar v. Jewish Hosp. Healthcare Servs., Inc.*, No. 2003-CA-000225-MR, 2004 WL 362281 (Ky. Ct. App. Feb. 27, 2004).

A physician’s resignation from a hospital while under investigation for quality of care issues triggers the reporting requirement under the HCQIA.

VI. LICENSING AND PROFESSIONAL DISCIPLINE

**California Appeals Court Rules Medical Board Could Not Revoke Physician’s License Based Solely on Failure to Complete Substance Abuse Diversion Program**

The California Medical Board (Board) revoked Dr. Lee Roy Liskey’s medical license after he refused to undergo inpatient treatment for substance abuse. Liskey previously had successfully completed a six-month outpatient treatment program through the Board’s diversion program. Subsequently, Liskey tested positive for cocaine use on two occasions. Although follow-up testing came back negative, the Board insisted Liskey undergo inpatient treatment. Liskey refused, and the diversion committee terminated him from the program. The Board sought the revocation or suspension of his medical license on the basis that (1) his ability to practice competently was impaired due to mental and/or physical illness, and (2) he had failed to complete successfully the diversion program in which he had agreed to participate. An administrative law judge (ALJ) concluded that Liskey was not subject to discipline because the Board failed to prove that his ability to practice medicine competently was impaired. The Board adopted the ALJ’s finding that no cause for discipline existed but concluded that it was legally required to revoke Liskey’s license for his failure to complete the diversion program. Liskey petitioned for judicial review. A trial court concluded that the Board lacked authority to discipline Liskey “for the mere failure to complete the medical board’s own diversion program.” The Board then petitioned for writ of mandate.

The California Court of Appeal denied the Board’s petition, finding that neither the relevant statute nor the agreements Liskey signed before entering the diversion program gave him adequate notice that he could be disciplined solely for failing to complete the program. The appeals court said that a statute authorizing the Board to
impose discipline against a medical license must include some reasonably clear identification of the basis for imposing discipline. Moreover, to justify the discipline, some nexus between an act or omission and the professional’s fitness or competence to practice must exist.

**Medical Bd. v. Superior Court for the City and County of San Francisco**, 4 Cal.Rptr.3d 403 (Cal. Ct. App. 2003).

_The failure of a physician to complete a substance abuse diversion program without clear and convincing evidence of impairment is not sufficient to revoke a physician’s license._

**New York Appeals Court Holds Favorable Outcome to Medical Disciplinary Proceeding Must Be Kept Confidential**
In October 1999, the Department of Health (DOH) State Board of Professional Medical Conduct (Board) issued a statement of charges against a general practitioner (petitioner) for allegedly treating an individual for a minor condition using a procedure for which he was not certified and for failing to maintain a medical record. A Board hearing committee found that the DOH had failed to prove that petitioner practiced medicine beyond the scope permitted by law, but that petitioner failed to maintain a medical record after issuing a prescription to the patient. The hearing committee issued a reprimand for the single charge of misconduct based on the failure to maintain a medical record. The DOH Bureau of Professional Conduct (Bureau) published on its official Web site the full text of the statement of charges and determination and order, which included allegations not sustained against petitioner. Petitioner requested that the Bureau remove all allegations that were not proven. The Bureau refused the request. Petitioner sued the Bureau and Board (“respondents”) for violation of N.Y. Pub. Health Law § 230(10)(g). The New York Supreme Court dismissed the proceedings, and petitioner appealed.

The New York Supreme Court, Appellate Division, directed respondents to withdraw from its Web site any portions of records that related to charges that were not sustained. The appeals court noted a policy of keeping disciplinary proceedings confidential until the proceedings are concluded in order to protect a professional’s reputation from harm arising from unfounded accusations. The appeals court found respondents’ premise that ongoing proceedings must be kept confidential, but once a determination is made that the charges were unfounded there is absolutely no protection, was “utterly devoid of logic.” The appeals court held that, under the statute a favorable determination was not required to be made public.


_The confidentiality of physician disciplinary proceedings must be maintained during and after the proceedings with respect to unsubstantiated charges_
California Appeals Court Says Hospital Must Give Physician Hearing Before, Not After, Terminating his Privileges

A physician whose hospital staff privileges were terminated should have been given a hearing before the revocation in accordance with statutory requirements. The California Court of Appeal reversed the lower court’s decision that denied the physician’s request for a preliminary injunction to reinstate his privileges pending such a hearing. The post-termination hearing that the hospital made available to the physician as an internal remedy was not a sufficient substitute for the statutorily mandated pre-termination hearing.

Defendant hospital appointed plaintiff physician to its medical staff for a two-year term. After twice reappointing him, the hospital medical staff began an investigation of plaintiff for alleged improper behavior involving derogatory comments and deceptive conduct in dealing with coworkers. Defendant eventually decided to deny plaintiff’s reappointment application, effectively terminating his privileges. Plaintiff filed an action seeking reinstatement of his privileges. The trial court denied plaintiff’s motion. The appeals court disagreed, stating the lower court erred in denying plaintiff’s injunction based on a lack of probability of success on the merits. According to the appeals court, the relevant inquiry was whether plaintiff would likely prevail on his claim that his procedural rights were violated by the hospital’s action. Noting its earlier conclusion that plaintiff should have been afforded a pre-termination hearing, the appeals court held that plaintiff had adequately established a likelihood of success on the relief he sought at this stage—reinstatement of his privileges pending a hearing. Sahlolbei v. Providence Healthcare, Inc., 112 Cal.App.4th 1137 (2003).

Pursuant to state law, a hospital must give physician a hearing before, and not after, terminating his privileges.

Maryland Appeals Court Rules Physician Could Not Refuse to Turn Over Patient Medical Records Pursuant to Valid Medical Board Subpoena

The Maryland Court of Special Appeals upheld a medical board decision to revoke a physician’s license for failing to cooperate with an investigation of her practice. Physician had refused to comply with an administrative subpoena issued by the board for the medical records of nineteen patients. The appeals court found the physician should have produced the medical records pursuant to the subpoena because the board was conducting a valid investigation into her medical practice. The appeals court rejected physician’s argument that turning over the medical records would violate her patients’ privacy rights, noting that state law protecting the confidentiality of medical records specifically recognizes the use of such records without consent in certain administrative and judicial proceedings.

The appeals court further found without merit physician’s contention that the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy regulations precluded her from complying with the subpoena. The appeals court noted that, at the time the board issued its decision, the HIPAA privacy regulations were not
in effect. Moreover, even if they had been in effect, the HIPAA regulations are not applicable to disclosures of medical records to a licensure or disciplinary agency, such as the board.


A physician subject to a valid medical board subpoena cannot refuse to turnover patient medical records.

**VII. MEDICAL STAFF ISSUES**

**U.S. Court in New York Dismisses Suit for Failure to Exhaust Administrative Remedies**

In 1996, plaintiff physician bought the practice of a pulmonologist from defendant hospital, which was selling the practice on behalf of the pulmonologist. The hospital arranged for plaintiff to have an office in the building across the street. Plaintiff was often critical of the quality of care provided by the hospital and voiced her concerns to hospital management with no results. Shortly before a scheduled evaluation of the hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in spring 2001, plaintiff made an appointment to meet with JCAHO about her concerns. Plaintiff cancelled the appointment after hospital staff and administrators warned her not to complain to JCAHO. Shortly after that, plaintiff, who is a Pakistani Muslim, claimed she was a target of racial remarks by hospital. In September 2001, an ad hoc committee at the hospital informed plaintiff that her conduct was erratic and she would have to submit to a mental examination. Plaintiff was also informed that the ad hoc committee had reviewed her patients’ charts and found her care to be substandard. The mental examination revealed no mental disorders, and further peer review found plaintiff’s care to be appropriate.

Physician did not timely file her renewal application for her contract with the hospital, and the hospital refused to renew her lease for the office space. Plaintiff alleged that the hospital and some of its management were responsible for two other hospitals refusing to consider her for privileges. Plaintiff sued the hospital and its management, claiming racial motivation for the failure to renew her contract and in blocking her efforts to obtain employment at other hospitals. The U.S. District Court for the Southern District of New York granted defendants’ motion to dismiss on the ground that plaintiff had to initially file her claim with the Public Health Council, as required by state law.


**Physician must exhaust all administrative remedies as required by state law.**
Tennessee Supreme Court Says Hospital Has Authority to Enter into Exclusive Provider Agreement for Imaging Department and Close Department to Medical Staff

The Cookeville Regional Medical Center Authority (Authority) operated a private act hospital. Defendants, who had staff privileges with the hospital, applied for a certificate of need to perform outpatient imaging services in competition with the hospital. The hospital decided to seek an exclusive provider for its imaging department, resulting in the defendants’ inability to continue to provide services in the imaging department. The hospital sought declarative relief that it could close the imaging department to the medical staff because of the exclusive provider agreement. The trial court granted the hospital declarative relief and also held that the bylaws did not give the medical staff the right to veto the decision to close the department. The appeals court affirmed.

The Tennessee Supreme Court affirmed, concluding: (1) the Hospital Authority Act gives a metropolitan hospital the authority to enter into a contract regardless of the competitive effect, and gives the hospital authority to enter into an exclusive provider contract, (2) a plain language reading of the medical staff bylaws provides that the medical staff will be consulted and have an opportunity to provide input, such input is advisory with the hospital’s board retaining the final decision making authority, and (3) although the high court found that the Authority was a state entity and deprivation of hospital privileges is a property interest, the medical staff bylaws allows the Authority to enter into an exclusive provider agreement for business purposes. Furthermore, the high court noted that the bylaws do not give defendants a reasonable expectation that they will be afforded a notice and hearing for a strictly business decision. The high court concluded defendants had no protectable property interest in the loss of their privileges by the closing of the imaging department to the hospital staff. City of Cookeville v. Humphrey, 126 S.W.3d 897 (Tenn. 2004).

A hospital operating under the Hospital Act has the authority to enter into an exclusive provider agreement and close a department to medical staff; therefore, a physician has no protectable property interest in the loss of privileges as a result of the closing of the department to the medical staff.

VIII. PHYSICIAN PRACTICE ISSUES

Ninth Circuit Upholds California Law Prohibiting Physician from Advertising as Board Certified Unless Certifying Organization Meets Statutory Standards

A California law that prohibits physicians and surgeons from advertising that they are board certified unless the certifying organization meets certain statutory requirements is not an unconstitutional regulation of free speech, the Ninth Circuit held. The appeals court found that the advertising at issue was inherently misleading commercial speech and therefore not protected under the First Amendment. The appeals court pointed out that the physicians were only prohibited from using the term “board certified” and could still advertise their membership in the non-certified organization. The legislature intended the term “board certified” to connote a certain level of formal education and
experience in which consumers and the medical community could rely, the appeals court decided.

The Academy of Pain Management, a nonprofit organization that developed standards and issued credentials for multidisciplinary pain practitioners, brought this action disputing the California law. The appeals court concluded that the regulation of the commercial speech involved here was permissible under the four-part analysis set forth by the U.S. Supreme Court’s Central Hudson case. American Acad. of Pain Management v. Joseph, 353 F.3d 1099 (9th Cir. 2004).

Physicians’ use of the term “board certified” is inherently misleading and can be regulated by the state as unprotected speech.

IX. ZONING

D.C. High Court Affirms Grant of Certificate of Need for Dialysis Facility, Says Agency Director Was Not Bound by Draft Health Plan Chapter on Dialysis Services
In early 2000, Capitol Dialysis LLC (Capitol) applied for a certificate of need (CON) for a freestanding dialysis center. At that time, the State Health Planning and Development Agency (SHPDA) was using a draft chapter on end-stage renal disease services as part of its Health Systems Plan for the District of Columbia. The draft chapter projected a need for 291 dialysis centers by 2002, but the District already had 326. The SHPDA Director issued a CON in July 2000. Fresenius Medical Care North America (Fresenius), an existing dialysis provider, filed a request for reconsideration. The Director denied the request, and Fresenius filed an administrative appeal with the D.C. Board of Appeals and Review (BAR). Capitol filed a motion to dismiss the appeal. The BAR held the denial of reconsideration was a final appealable decision and denied the motion, but upheld the grant of the CON.

The District of Columbia Court of Appeals affirmed the grant of the CON. As a threshold matter, the high court held the BAR had jurisdiction to consider Fresenius’ appeal, and therefore it had jurisdiction as well. The high court noted its review was limited to determining if the BAR had made findings of fact that were based on substantial evidence and had drawn a reasonable conclusion. The court rejected Fresenius’ argument that SHPDA had disregarded the draft chapter’s projections, explaining that the draft chapter was provisional and not final. Agreeing with the BAR’s explanation that the Director did not act unreasonably in rejecting the draft chapter’s projections, the high court found the evidence supported the determination that the District needed a new dialysis facility to improve quality and accessibility. Bio-Medical Applications of D.C. v. D.C. Bd. of Appeals and Review, 829 A.2d 208 (D.C. 2003).

The rejection of a non-binding draft plan was within the discretion of the Agency Director in granting a Certificate of Need.
U.S. Court in Maryland Holds Plaintiff Alleged Sufficient Facts to Survive Motion to Dismiss ADA Claims After Denial of Zoning Permit

In 2001, plaintiff corporation, which was formed to provide methadone maintenance services to individuals with drug addiction, attempted to open a methadone clinic in Baltimore County, Maryland. The County denied plaintiff a necessary zoning permit. Plaintiff sued, claiming violations of the Americans with Disabilities Act (ADA) and other statutes.

The U.S. District Court for the District of Maryland stated that plaintiff had a right to provide services without discrimination. The court determined that there were a number of potential problems with plaintiff’s claim, but that the issue was better left until a later stage of the litigation. The court did say, however, that plaintiff’s claim might be dismissed, but there was no need to address the issue at this point in the litigation because the remedies under the two titles within the ADA are identical. START, Inc. v. Baltimore County, 295 F. Supp. 2d 569 (D. Md. 2003).

*ADA claim survives based on the allegation of sufficient facts after denial of zoning permit.*
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I. LABOR

**National Labor Relations Board Interprets Notice Provision in Favor of Minnesota Clinic**

Section 8(g) of the National Labor Relations Act (Act) requires unions to give healthcare institutions ten days’ notice of their intent to strike. The Minnesota Licensed Practical Nurses Association (Union) rejected the Alexandria Clinic’s (Clinic) offer and voted to strike. By letter dated August 30, 1999, the Union informed the Clinic that it would strike at 8:00 a.m. on September 10, 1999. Without notifying the Clinic or the nurse employees, the Union changed the beginning time of the strike from 8:00 a.m. to noon. Believing the strike would occur at 8:00 a.m., the Clinic hired replacement nurses who were waiting on site to step in when the strike began. The employee nurses worked their usual shift until shortly before noon, when they were instructed to gather outside as the strike was imminent. Employee nurses scheduled for shifts after noon did not report to work. The replacement nurses stepped in for the striking nurses. The Clinic wrote the Union asking why the strike was delayed and why the Clinic was not notified. The Union responded that it gave the proper notice and went out on strike within the allowable time. Asserting that the striking nurses’ walkout was in violation of the notice provisions of § 8(g), the Clinic terminated their employment.

The NLRB held that a union cannot unilaterally extend the commencement time of its strike. Unlike unrepresented nurses, Congress deliberately legislated that § 8(g) covers nurses represented by unions with respect to the notice requirements. Accordingly, termination of the nurses was not a violation of the Act. *Alexandria Clinic*, 339 NLRB 162 (2003).

*Union may not unilaterally delay the commencement time of a strike after giving notice of the intent to strike.*

**NLRB Says Bargaining Unit Limited to One Clinic Was Inappropriate in Case in Which Clinics Operated as Single Network**

St. Luke’s successfully rebutted the presumption in the healthcare industry that a single-facility bargaining unit is appropriate. St. Luke’s operated a healthcare system that included a network of twenty-one clinics in sixteen different locations. Eleven of the clinics were located within ten miles of each other. United Food and Commercial Workers Local 222 petitioned for an election to represent registered nurses, a medical technologist, a nurse practitioner, and a physician’s assistant in Sunnybrook family practice clinic, which employed RNs, a medical technologist, a nurse practitioner, and a physician’s assistant. St. Luke’s appealed from the decision of a National Labor Relations Board (Board) regional director, who found the proposed unit would be appropriate if it also included nurse practitioners and physicians assistants. St. Luke’s argued that the smallest appropriate unit would consist of all
professional employees, except the physicians, at all twenty-one clinics. This included 121 employees in eleven professional job categories.

A divided panel of the Board reversed the regional director’s decision and found that a bargaining unit limited to the Sunnybrook clinic was inappropriate because St. Luke’s had demonstrated that “the clinics operate as a single network and are functionally integrated both as to the services provided and as to the employees who provide them.” The Board found that St. Luke’s had established that patients could leave the acute care facility and receive a full range of benefits from the various clinics, and “virtually all of the clinics’ administrative operations are centralized.” Among other indicators, the Board found that the proximity of the sixteen locations supported a multifacility unit.


This case demonstrates that, if group of clinics operates as single network, a bargaining unit for a single facility within the network may be found inappropriate.

DC Circuit Says Private, Nonprofit Hospital Taking over Public Hospital Is Successor Under NLRA

For a number of years, Community Hospitals of Central California (Community) operated two hospitals in Fresno, California, while the county operated Valley Medical Center (Valley) and other facilities in the area. Valley nurses were members of Unit Seven of the California Nurses Association. In October 1996, Community acquired Valley and changed the name to University Medical Center.

The DC Circuit held that Community, a private, nonprofit hospital taking over a public hospital and instituting new management, was a successor employer under the National Labor Relations Act and was therefore required to bargain with Valley’s existing union. According to the appeals court, the critical point was that the facility “continued to function as a full-service, acute-care hospital where registered nurses used the same skills and equipment to provide care for the same general patient population.” In addition to finding that the National Labor Relations Board (Board) was correct on the succession issue, the appeals court agreed with the Board that the unit was an appropriate bargaining unit and that there was no basis to believe that the union lacked majority support. The appeals court stated that, “a bargaining unit limited to a single facility is presumptively appropriate” and “a group of employees with a significant history of representation by a particular union presumptively constitute an appropriate bargaining unit.” Thus, the appeals court rejected Community’s arguments that: (1) there was never a bargaining unit consisting only of nurses located at University Medical Center, and (2) that the “fully integrated” approach the company has to managing the hospital rebuts the presumption that the bargaining unit is appropriate.

Community Hosps. v. NLRB, 335 F.3d 1079 (D.C. Cir. 2003).
This case illustrates that purchasers of hospitals must consider their status as a successor employer in cases in which the facility continues to operate as it did prior to purchase.

II. ERISA

Supreme Court Says “Treating Physician Rule” Does Not Apply to ERISA Plans

Plaintiff was enrolled in the Black & Decker Company’s disability plan (“Plan”). After plaintiff began suffering from hip and low back pain, he consulted a physician, who concluded that he was unable to work. Plaintiff submitted a claim for disability benefits under the Plan, which referred him to a physician for an independent medical evaluation of his claim. The Plan’s physician concluded that plaintiff suffered from recurrent back pain, but found him physically capable of performing his job if he took prescribed pain reduction medication. Based on this conclusion, the Plan denied plaintiff’s claim for disability benefits. Plaintiff sued the Plan, asserting that the denial of his claim violated ERISA. The district court ruled in favor of the Plan, but the Ninth Circuit applied its “treating physician rule” and reversed the district court’s ruling.

The U.S. Supreme Court unanimously rejected the application to the “treating physician rule” to ERISA claims. The Court noted that the blanket application of the rule to ERISA plans ignores significant differences between Social Security disability claims and disability claims under ERISA. While Social Security is a mandatory federal program, ERISA does not require employers to adopt disability plans and provides great flexibility to employers in designing such plans. Moreover, an employee’s entitlement to disability benefits under an employer’s ERISA plan depends upon the terms of that specific plan, whereas Social Security operates under a uniform definition of disability. Finally, the Court noted that the Ninth Circuit lacked the authority to impose the “treating physician rule” on ERISA plans by judicial fiat where Congress had declined to do so.


This case signifies a court’s lack of authority to impose a treating physician rule on ERISA plans.

III. AGE DISCRIMINATION

Supreme Court Holds That Employer May Provide Older Workers Health Benefits Without Providing Same Benefits to Younger Employees

Prior to a 1997 revision to a collective bargaining agreement (CBA), General Dynamics (GD) provided health benefits to retirees with thirty years’ seniority. The 1997 revision eliminated GD’s obligation to provide health benefits to future retirees except for current employees who were fifty and over at the time of the revision. A group of employees between the ages of forty and fifty sued GD for violation of the Age Discrimination & Employment Act (ADEA), claiming that, because they were in
the statute’s protected class, GD could not provide health benefits to employees over fifty without providing the same benefits to employees between forty and fifty. Plaintiffs asserted that the ADEA specifically prohibits discrimination because of an “individual’s age.” Accordingly, they argued that GD could not discriminate against younger employees who were protected by the Act.

The U.S. Supreme Court held that the ADEA was intended to prohibit discrimination against older employees, not younger employees, and thus found that the act does not protect plaintiffs, even though they are in the protected class, because older employees received favorable treatment. This decision directly opposed plaintiffs’, and the EEOC’s, position. This decision has broad applicability to employers who decide they want to provide health benefits, severance benefits, early retirement packages, or the like to a defined group of older employees without having to provide the same benefits to all employees age forty and over. For example, if an employer would like to offer an early retirement program to its employees age sixty and older, but refrain from providing the same early retirement option to employees age forty to sixty, they now have the Supreme Court’s blessing.


This decision has broad applicability to employers who decide they want to provide health benefits, severance benefits, early retirement packages, or the like to a defined group of older employees without having to provide the same benefits to all employees age forty and over.

IV. DISABILITY DISCRIMINATION

U.S. Supreme Court Will Address Whether ADA Trumps No-Rehire Policies in Cases in Which Employee’s Only Work-Related Offense Was Drug Use

The Supreme Court will determine, in a case of first impression, whether the Americans with Disabilities Act (ADA) trumps no-rehire policies where the reason involves illegal drug use. After a positive drug test, the plaintiff quit in lieu of discharge. The employer was aware of plaintiff’s drug and alcohol problem. The plaintiff applied for re-employment two years later, and the employer denied his application based on its policy of not rehiring former employees who were terminated or quit in lieu of termination. Plaintiff sued under the ADA.

The Ninth Circuit held that the policy violated the ADA as applied to former drug addicts whose only work-related offense was testing positive for drugs because of their addiction. The appeals court explained that, if the plaintiff is rehabilitated, he may not be denied re-employment because of his past record of drug addiction.

The United States Supreme Court will decide whether the ADA trumps no-rehire policies where the reason the employee originally terminated his employment was illegal drug use.

**Tenth Circuit Holds in Favor of Deaf Applicant**

In the past, America Online (AOL) has hired voice and non-voice phone operators; the company had hired deaf individuals as non-voice, or telecommunication for the deaf (TTD), operators. In 1998, AOL adopted a policy of considering only internal employees for TTD operator positions. Even though AOL currently had six deaf employees, as a consequence of this policy, no new deaf people were considered for employment because they were not qualified to hold a voice operator position. Plaintiff sued, claiming that AOL discriminated against him by refusing to hire him because he was deaf.

The Tenth Circuit found plaintiff was a “qualified individual with a disability” although he was not an incumbent employee, reasoning that a person is a “qualified individual with a disability if that individual can perform the essential functions of the employment position that he holds or desires.” Even though AOL considered voice-phone operator experience to be an essential prerequisite for the position of non-voice phone operators, the controlling test was whether removing the function would fundamentally alter the position at issue. The court also addressed whether the “continuing violations” doctrine was applicable to AOL’s earlier refusal to hire plaintiff. The court reasoned that, even if the discriminatory acts complained of were the result of a company-wide policy, they were still separate “discrete” acts because plaintiff was not complaining about the policy in general; rather, he was challenging the two individual incidents in which AOL refused to hire him. The case was remanded for consideration in light of the factors enumerated by the court. **Davidson v. America Online, Inc.,** 337 F.3d 1179 (10th Cir. 2003).

This case is significant because it provides guidance on determining the essential functions in a hiring case.

**Second Circuit Says Getting Along With Others Is Essential Job Function of Supervisory Position**

Plaintiff began working for defendant, a center that aided retarded children, in 1984. She received several promotions, the most recent being a promotion to associate director in April 2000. In October 2000, plaintiff was involved in a verbal altercation with a subordinate whose child was a client of the center. The subordinate subsequently resigned as a result of abusive and intimidating conduct by plaintiff, but continued to visit her child at the center. In mid-October 2000, plaintiff, who took medication for anxiety and took time off from work for psychiatric counseling, suffered an anxiety attack that required her to take time off from work. After two weeks off, plaintiff returned to work on a half-day schedule for one week. Citing her lack of managerial skills to serve as associate director, the center terminated plaintiff on November 3, 2000.
On appeal, plaintiff argued (1) that her supervisor regarded her as disabled within the meaning of the Americans with Disabilities Act because of her psychiatric disorders, and (2) that defendant failed to accommodate her disability by refusing to bar the former subordinate from the building and refusing to permit plaintiff to leave when the former employee visited her child. The court held that plaintiff was not a “qualified individual with a disability” because she could not get along with others, an essential function of a supervisory position. Nor did plaintiff establish that her supervisor regarded her as disabled. The evidence merely indicated that her supervisor believed plaintiff to be unfit for the position of associate director. The court declined to address the accommodation issue.

**Cameron v. Community Aid for Retarded Children, Inc.,** 335 F.3d 60 (2d Cir. 2003).

_The Second Circuit provides emphasis on whether an individual is qualified for a particular position before addressing the issue of disability._

**Third Circuit Provides Guidance on Role of Employee Who Requests Accommodation**

Plaintiff suffered from depression, for which her doctor prescribed a medication that made it difficult for her to get up in the mornings. Although MBNA agreed to accommodate this condition by allowing plaintiff to report to work at 9 a.m. rather than 8 a.m., plaintiff was still frequently late. When a new supervisor met with plaintiff regarding her schedule, plaintiff agreed to arrive at 8 a.m. However, plaintiff soon began arriving late again. When asked to explain her tardiness, plaintiff refused to give a reason, but promised to be on time in the future. Plaintiff was unable to keep the promise and was terminated for excessive tardiness.

The Third Circuit affirmed the lower court’s entry of summary judgment against plaintiff, finding plaintiff responsible for the breakdown of the interactive process required under the Americans with Disabilities Act (ADA). The appeals court commented:

> MBNA cannot be held liable for failing to read . . . tea leaves. [Plaintiff] had an obligation to truthfully communicate any need for an accommodation, or to have her doctor do so on her behalf if she was too embarrassed to respond to MBNA’s many inquiries into any reason she may have had for continuing to be late.

**Conneen v. MBNA America Bank,** 334 F.3d 318 (3d Cir. 2003).

_This case it places an obligation on an employee to make known his or her need for an accommodation. An employer cannot be held liable under the ADA unless that employer knows or has reason to know that an employee is disabled and needs a reasonable accommodation._
Seventh Circuit Says ADA Retaliation Plaintiff Could Not Recover Compensatory or Punitive Damages
The Seventh Circuit ruled that a plaintiff who claimed retaliation under the Americans with Disabilities Act (ADA) could not recover compensatory or punitive damages and had no right to a jury trial. This was a case of first impression in the Court of Appeals, and the district courts are split on the issue. The decision turns on whether the 1991 Civil Rights Act that expanded the remedies to certain listed claims included claims under the ADA. The Seventh Circuit ruled that, because the 1991 amendment did not specifically list ADA retaliation, the expanded remedies are not available for that claim. Kramer v. Banc of America Secs. LLC, 355 F.3d 961 (7th Cir. 2004).

The Seventh Circuit was the first appeals court to address the issue of whether remedies under the 1991 Civil Rights Act are available to claims of retaliation under the ADA.

Eighth Circuit Holds That ADA Protects Workers Against Disability-Based Hostile Environments
Plaintiff had suffered from epilepsy since he was a teenager. After an operation in which part of his brain was removed and replaced by a metal plate, he was able to get a job at a timber mill. After being fired, allegedly for insubordination, plaintiff sued his employer under various theories, including hostile work environment in violation of the Americans with Disabilities Act (ADA).

The Eighth Circuit held that the ADA protects workers against disability-based hostile environments, but found that plaintiff did not show that his work environment was sufficiently severe. The appeals court held that evidence that plaintiff was called “platehead,” and was regarded as stupid and “not playing with a full deck” by co-workers, did not rise to the objective level of harassment found actionable in hostile environment cases involving other types of bias. Thus, the appeals court concluded that summary dismissal of plaintiff’s harassment claim was warranted. Borrowing from hostile environment cases decided under other federal employment bias laws, the appeals court explained that plaintiff could prevail by showing that: (1) he is a member of a protected class, (2) he was subjected to unwelcome harassment, (3) the harassment resulted from his membership in the class, and (4) the harassment was severe enough to affect the terms, condition and privileges of his employment. Although the appeals court noted that plaintiff had offered sufficient evidence of impairment, that he was regarded as disabled, and that he was subjected to unwelcome harassment, the court found that the verbal harassment to which plaintiff was subjected was not of the requisite level of objective offensiveness to give rise to a claim. Shaver v. Independent Stave Co., 350 F.3d 716 (8th Cir. 2003).

This case is significant because a federal court is defining the standard for which verbal harassment is considered sufficiently offensive to constitute an ADA claim.
V. RACIAL DISCRIMINATION

Supreme Court Addresses Role of Affirmative Action in College Admissions
The University of Michigan’s undergraduate admissions policy was based on a point system that automatically granted twenty points to applicants from underrepresented minority groups. A class of individuals, who had applied for and were denied admission to the university for academic year 1995 and forward and who were members of racial or ethnic groups that the university treated less favorably on the basis of race, brought suit alleging race discrimination under the Equal Protection Clause, Title VI, and 42 U.S.C. §1981.

The case made it to the Supreme Court, which rejected plaintiffs’ argument that diversity could not constitute a compelling state interest. The Court found, however, that the policy of automatically distributing twenty points, or 1/5 of the points needed to guarantee admission, to every single underrepresented minority applicant solely because of race, was not narrowly tailored to achieve educational diversity. The Court explained that the university needed to conduct more individualized consideration rather than an automatic distribution of points.

In a companion case, the Supreme Court considered whether the university’s policy on law school admission violated the Equal Protection Clause and Title VI. A white Michigan resident with a 3.8 GPA and 161 LSAT was rejected because the law school used race as a significant factor. The Supreme Court held in favor of the university, finding that the law school’s narrowly tailored use of race in admissions decisions furthered a compelling state interest in obtaining the educational benefits that flow from a diverse student body. The law school’s admission program was considered a narrowly tailored plan because (1) it only considers race as a “plus” on a student’s application, (2) the plan is flexible enough to consider all pertinent elements of diversity, not just race, and (3) there is no policy either de jure or de facto of automatic acceptance or rejection based on variables such as race or ethnicity.


*These cases are significant because they provide guidance on the extent to which a university may use affirmative action in its admission policies.*

Supreme Court Eases Plaintiffs’ Burden in Mixed-Motive Cases
Plaintiff’s sex-discrimination claim was submitted to the jury on a mixed-motive instruction. The jury found for plaintiff and awarded damages. The appeals court initially vacated and remanded, holding that the district court had erred in giving the mixed-motive instructions; after an en banc rehearing, the district court’s judgment was reinstated. Certiorari was granted by the Supreme Court to decide whether a plaintiff must present direct evidence of discrimination in order to obtain a mixed-motive instruction under Title VII, 42 U.S.C. § 2000(e)(2)(m). A “mixed-motive” case is one in which a plaintiff demonstrates that race, color, religion, sex, or national origin was a motivating factor for an employment practice, even though other factors also
motivated the practice. Prior to the Civil Rights Act of 1991, an employer could evade liability in a mixed-motive case. Subsequent to the Act, the employer is entitled to an affirmative defense that does not absolve it of liability, but does restrict the available remedies to declaratory relief, certain injunctive relief, and attorney’s fees and costs. To avail itself of the defense, the employer must demonstrate that it would have taken the same action in absence of the impermissible motivating factor.

A unanimous U.S. Supreme Court held that a plaintiff need not present direct evidence of discrimination in order to obtain a mixed-motive jury instruction under Title VII. The Court looked first to the statutory text and determined that it unambiguously required that a plaintiff “demonstrate” only that an employer had used a forbidden consideration, not that she make a heightened showing through direct evidence. Title VII’s silence as to the type of evidence required an analysis of the term “demonstrates” in other Title VII provisions and was a factor in the Court’s conclusion that no heightened showing is required under § 2000(e)(2)(m).


Desert Palace may be the most significant Title VII decision since the Civil Rights Act of 1964 was amended in 1991 because it allows a plaintiff to proceed on a showing of circumstantial evidence even when an employer may have a legitimate business reason for the employment action.

Eighth Circuit Upholds Preemptory Challenge of Only African-American Juror on Panel
Plaintiff sued for race, sex, and age discrimination. Plaintiff alleged that, during the course of his employment, his male supervisor touched him in sexually inappropriate manners, made sexually explicit comments to him, and referred to him by such names as “boy” and “black boy.” Plaintiff was eventually fired after an argument with a customer who had made racially derogatory comments toward him.

At trial, the defense excluded a juror who was employed by the Kansas City school district because defendant’s attorney had represented the other party in a highly publicized and acrimonious lawsuit involving the school district. On appeal, plaintiff argued that the court erred when it upheld the preemptory challenge of the juror, who happened to have been the only African-American on the panel. The appeals court affirmed the lower court, noting that the white jurors on the panel were not in comparable situations to the African-American juror because they had different experiences and backgrounds. Therefore, the lower court had not erred when it upheld the preemptory challenge.

Elmahdi v. Marriott Hotel Servs., Inc., 339 F.3d 645 (8th Cir. 2003).

This case addresses the Batson challenge in a civil employment action. The court held that the defendant’s preemptory challenge would be upheld as long as they also challenged white jurors with comparable or similar characteristics.
Sixth Circuit Dismisses Title VII Case Because, as Independent Contractor, Surgeon Was Not Protected by Title VII

For more than twenty years, Dr. Bhanukumar Shah held unrestricted surgical privileges at Deaconess Hospital (Deaconess). In 1998, a surgical patient of Shah’s died after her operation. Deaconess’s clinical review committee found that “a serious misjudgment occurred in the management” of the deceased patient. The Board of Trustees for Deaconess then revoked Shah’s privileges to perform head and neck surgery and imposed a one-year period of more stringent monitoring of his performance. Shah sued Deaconess Hospital, claiming age discrimination in violation of the Age Discrimination & Employment Act (ADEA) and national origin discrimination in violation of Title VII. The court granted Deaconess’s motion for summary judgment, and Shah appealed.

The Sixth Circuit analyzed Shah’s relationship with Deaconess to determine whether Shah was an employee of the hospital or whether he was an independent contractor and thus not protected by Title VII or the ADEA. The appeals court joined the Fourth, Fifth, and Seventh Circuits by holding that a physician denied hospital privileges is not protected by the federal employment discrimination statutes if he or she is an independent contractor. The appeals court concluded that Shah was an independent contractor based on several facts, including that Shah (1) treated his own patients and contracted freely with other hospitals, (2) was under no obligation to accept patients referred to him by Deaconess, and (3) was not treated as an employee of Deaconess for tax purposes. Thus, the appeals court dismissed Shah’s claims because, as an independent contractor, the federal statutes did not protect him.


This case demonstrates the lack of federal discrimination protection for independent contractors.

VI. OTHER DISCRIMINATION AND RETALIATION CASES

In Hill v. Lockheed Martin Logistics Mgmt., Inc., 354 F.3d 277 (4th Cir. 2004), the Fourth Circuit found no liability for the company charged with sex and age discrimination based on the acts of an influential biased co-worker who was not a decision maker. The court was split 7-4. One of the dissenting judges wrote, “[a]fter today in this circuit, an employer is off the hook for a discriminatory employment decision that is motivated by the bias of a subordinate who lacks decision-making power. That is wrong.”

In Daka, Inc. v. McCrae, 839 A.2d 682 (D.C. 2003), the District of Columbia Court of Appeals vacated a jury award of $4.8 million to a former employee of Howard University who claimed sexual harassment. Relying on a recent U.S. Supreme Court decision on punitive damages, (State Farm Mut. Auto Ins. Co. v. Campbell, 538 U.S. 408 (2003), the Court stated, “Although the facts . . . justified a significant award of punitive damages, the sum awarded—reflected a ration of 26:1 to the compensatory
damages award—lacked the reasonableness and proportionality required of a punitive damages award."

In *Slivka v. Camden-Clark Mem'l Hosp.*, 594 S.E.2d 616 (W. Va. 2004), the West Virginia Court of Appeals reversed the trial court’s summary judgment dismissing the plaintiff’s claim that a hospital illegally denied him a job in the obstetrics unit because he is a man. The court adopted a three part test for deciding whether privacy interests justify a particular sex as a bona fide occupational qualification and remanded the case for a determination of the extent of the privacy concerns of the patients.

In *Grant v. Fairview Hosp. & Healthcare Servs*, No. 02-4232, 2004 WL 326694 (D. Minn. Feb. 18, 2004), the U.S. District Court for the District of Minnesota decided that the employer was not under an obligation to allow employees to impose their religious views on others. In granting summary judgment to the employer, the court upheld the termination of an ultrasound technician in a Minneapolis area clinic who was fired for proselytizing against abortion. In finding no religious discrimination, the court held that the clinic made a reasonable accommodation to the religious needs of the former employee by allowing him to leave the room and terminate his examination of patients who were considering abortion, but it had no obligation to agree to allow him to counsel these patients.

**VII. FAMILY AND MEDICAL LEAVE ACT**

**Eleventh Circuit Says Employees Must Experience Three Full and Consecutive Days of Incapacitation to Qualify for “Serious Health Condition” Under FMLA**

The Eleventh Circuit upheld a Labor Department regulation requiring that an employee be incapacitated for three full and consecutive days to have a serious health condition under the Family and Medical Leave Act (FMLA). The appeals court rejected the argument that partial days of incapacity count toward the three-day threshold. Plaintiff, a hospital employee, slipped and fell on the job, aggravating an existing wrist condition, fracturing her right elbow, and fracturing her ankle. Over the next ten days, plaintiff was absent intermittently. At least twice, she did not call to explain her absence. She was fired for excessive absenteeism. Plaintiff sued, claiming the hospital retaliated against her for exercising her FMLA rights and contending that she had established seven consecutive partial days of incapacity. The appeals court disagreed, finding that 29 C.F.R. § 825.114 requires full days of incapacity. According to the court, this regulation ensures that health conditions are in fact serious, and result in an extended period of incapacity, as Congress intended.


*This case demonstrates a federal court’s enforcement of a strict threshold for employees seeking FMLA protection.*
Third Circuit Holds That Employer’s Failure to Notify Employee of FMLA Rights Is Viable Cause of Action

Public Service Electric & Gas Company (PSE&G) accused employee Richard Conoshenti of keeping inaccurate time records and leaving his shift early. Conoshenti denied these claims, but PSE&G discharged him for violating company policy. Upon the advice of his union, Conoshenti entered into a last chance agreement (LCA) to keep his job. The LCA required Conoshenti’s reporting to work every day and on time. Conoshenti subsequently was involved in an automobile accident that required hospitalization and requested a leave of absence, which was granted. PSE&G failed to notify Conoshenti of his rights under the Family and Medical Leave Act (FMLA). When Conoshenti returned from his leave several days after his FMLA expired, PSE&G terminated him for violating the LCA. An arbitrator found that Conoshenti had violated the terms of the LCA. Conoshenti sought judicial review, and PSE&G removed the case to federal court. The court granted summary judgment in favor of PSE&G.

The Third Circuit reversed the grant of summary judgment and remanded the case for further proceedings. The appeals court found that Conoshenti stated a viable claim for relief based on PSE&G’s failure to notify him of his FMLA rights. The appeals court found that, if Conoshenti had received the required information, he could have structured his leave and recuperation so as to preserve the job protection afforded by the FMLA. Although the court observed that Conoshenti had presented no evidence that he would have made different choice had PSE&G informed him of his FMLA rights, the court said that PSE&G should not prevail on a motion for summary judgment, but bear the burden that Conoshenti could not structure his leave so as to preserve his protection under the FMLA. Conoshenti v. Public Serv. Elec. & Gas Co., 364 F.3d 135 (3rd Cir. 2004).

This case emphasizes the importance of notifying employees of their rights under the Family and Medical Leave Act.

Sixth Circuit Rules That Employer’s Internal Notification Requirements for Unplanned Leaves of Absence May Not Be More Restrictive Than Requirements for Planned Leaves

Plaintiff received an employee handbook containing Honda’s policies on absences and notification requirements. According to the handbook, employees were to report one-day absences or sicknesses to either the leave coordination department (Department) or to security. Absences of a longer duration, including extended absences due to serious injuries for purposes of FMLA, had to be reported to the Department within three business days of the absence. On June 21, 1999, plaintiff was injured in a motorcycle accident and went to the hospital, where a doctor gave him a note excusing him from work until June 24. A second doctor then extended the work excuse until June 28. Each day plaintiff called security, rather than the Department, to announce his absence. Honda disciplined plaintiff because he had violated its absence notification policy by failing to provide notice to the Department within three working days of the first day of absence. Honda eventually terminated
plaintiff after he missed additional days of work because of pain from his injuries. Plaintiff sued Honda, alleging interference with his FMLA rights. Honda moved for summary judgment, and the court granted the motion.

The Sixth Circuit reversed, holding that Honda’s internal absence policy was inconsistent with the FMLA’s notice requirements, and therefore void. The Sixth Circuit reasoned that Congress could not have intended for employers to have more restrictive notice requirements for unplanned leaves of absence than for planned leaves of absence and that such an interpretation would be contrary to the purpose of the FMLA. Accordingly, the court held that Honda’s requirement that plaintiff notify the Department, rather than security, was inconsistent with the FMLA.  


_This case demonstrates that company leave policies that are inconsistent with FMLA are void._

**VIII. WRONGFUL DISCHARGE ACTIONS**

**Tenth Circuit Says Plaintiffs Could Not Use Oklahoma Nursing Home Care Act to Establish Public Policy Exception for Termination of Their At-Will Employment**

Plaintiffs, a certified medication aide and cook at a residential care facility, suspected that an employee was stealing and using drugs from the facility’s medication room. Instead of following the chain of command, plaintiffs reported the employee to a medication consultant at the facility. They did not report it to the appropriate administrator, a close friend of the suspected employee. Plaintiffs were fired for not following the proper chain of command, and brought an action for wrongful discharge, asserting that they had performed an act encouraged by public policy: reporting a co-worker who was stealing medications from the elderly residents at the facility. Plaintiffs also asserted that the employer operated a nursing home governed by the Oklahoma Nursing Home Care Act (Act), which had a strong public policy in favor of whistleblowers. The employer asserted that it was a residential care facility governed by the Oklahoma Residential Care Act. A federal district court granted summary judgment against plaintiffs, who then appealed.

The Tenth Circuit affirmed. First, the appeals court found that, because plaintiffs had not presented any evidence to refute the employer’s license indicating it was a residential care facility, they could not use the Act to establish a public policy exception to their termination of their at-will employment. Furthermore, the appeals court found that plaintiffs had failed to raise a Residential Care Act argument until their appeal and that, therefore, such arguments were waived. Because plaintiffs had failed to identify any Oklahoma law that articulates a public policy sufficiently strong to prevent their termination, appeals court affirmed the decision of the district court granting summary judgment to the employer.  

_Wilburn v. Mid-South Health Development, Inc.,_ 343 F.3d 1274 (10th Cir. 2003).
This case illustrates a federal court’s reluctance to allow a public policy exception to termination of at-will employment.

Federal Jury in Virginia Awards Over $4 Million to Hospital Manager Who Attempted to Prevent Sexual Harassment in Operating Rooms
Stephanie Denninghoff had been the director of operative services and acting nurse manager at Bon Secours DePaul Medical Center (Bon Secours). Denninghoff received complaints that one of the nurses she oversaw was engaging in sexually harassing behavior in the operating room, including hugging, kissing, and rubbing doctors and staff. Denninghoff and the human resources department counseled the nurse about her behavior. Following the counseling, the nurse complained about being treated unfairly and quit. Several doctors complained to hospital management about Denninghoff’s addressing of the nurse’s behavior. One doctor threatened to remove his business from the hospital if Denninghoff was not terminated and the nurse brought back. A hospital administrator advised that Denninghoff’s handling of the situation alone did not merit Denninghoff’s discharge. A few months later Denninghoff was given the choice to resign or be fired for alleged breach of confidentiality regarding another matter.

At trial, the jury dismissed as pretext the hospital’s arguments for terminating Denninghoff for an alleged breach of confidentiality. The nurse who had resigned returned to work at the hospital six days after Denninghoff’s departure. The jury awarded Denninghoff $1.05 million in compensatory damages and $3 million in punitive damages. Compensatory and punitive damages are limited under Title VII of the Civil Rights Act to $300,000 for an employer of this hospital’s size, although there is no cap on front or back pay awards.


This award demonstrates a jury’s willingness to hold an employer responsible for wrongfully terminating an employee who attempted to resolve a sexual harassment issue.

IX. EMPLOYER LIABILITY ISSUES

Pennsylvania High Court Says Hospital That Collects Drug Testing Samples Owes Duty of Care to Those Undergoing Testing
Plaintiff, a courier for Federal Express, was directed to go to St. Luke’s Hospital (St. Luke’s) for routine, random drug screening. Pursuant to a contract with Federal Express, St. Luke’s collected urine samples and forwarded those samples to an outside laboratory for testing. Plaintiff argued that on the day of her testing, numerous events occurred that affected the chain of custody of her sample, resulting in misidentification or mishandling. Consequently, the urine sample falsely tested positive for cocaine and plaintiff’s employment with Federal Express was terminated. Plaintiff sued St. Luke’s, alleging the hospital “had a duty of care to perform specimen
collection in accordance with the Code of Federal Regulations governing specimen collection and in accordance with the requirements placed upon a medical facility performing to the appropriate and generally accepted standards for urine specimen collection."

The Supreme Court of Pennsylvania held that St. Luke’s owed a duty of care to plaintiff. The high court set out the factors to determine whether a duty should be imposed upon the hospital, explaining that the determination of whether a duty should be imposed on an alleged tortfeasor involves a balancing of the following factors: (1) the relationship between the parties, (2) the social utility of the actor’s conduct, (3) the nature of the risk imposed and foreseeability of the harm incurred, (4) the consequences of imposing a duty upon the actor, and (5) the overall public interest in the proposed solution. Finding these factors present, the supreme court held that the hospital owed plaintiff a duty of reasonable care with regard to the collection and handling of her urine specimen for the employment-related drug testing. The court noted that a jury must determine whether the hospital breached such duty.


*This case is important because it defines factors for determining whether a hospital owes a duty of care to patients who submit to drug testing at the facility, even if a third party laboratory performed actual test.*
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Sixth Circuit Upholds Immediate Jeopardy Finding for Faulty Beds
The Centers for Medicare and Medicaid Services (CMS) found that twelve of the fifty-three beds in a nursing home were unsafe due to malfunctioning side rails. In one instance, a resident fell from a bed that was known to have a side rail that collapsed easily. The resident was returned to the same bed and the rail collapsed again, in the presence of surveyors. A second resident fell twice from his bed, when the side rails malfunctioned. The state survey team found a violation of 42 C.F.R. § 483.25(h)(1) at a level of immediate jeopardy. Sanctions were imposed against MeadowWood, and MeadowWood filed an appeal. An administrative law judge upheld the deficiencies and sustained the penalties. The Departmental Appeals Board (DAB) affirmed the decision. MeadowWood argued on appeal that the standard being applied by CMS was strict liability.

The Sixth Circuit affirmed the DAB decision, finding that the record supported the DAB’s findings. The appeals court declined to address the issue of strict liability, explaining that it found “no merit to MeadowWood’s attempt to re-cast what is essentially a dispute of fact into a legal issue—indeed, we think that the strict liability argument is essentially a red herring.”


This case carries with it the implication that strict liability is not the standard to be applied.

Missouri Appeals Court Finds Defendants Criminally Accountable for Failing to Report Elder Abuse
Employees of AHM, the management company for Claywest House Healthcare (Claywest), were instructed they were not to hotline instances of abuse until they had contacted the corporate office and spoken either to Charles Kaiser III, AHM’s President and in-house counsel, or other persons as designated by Kaiser. Kaiser had a history of punishing employees who gave the state evidence of substandard care. Several employees had reported to Betty Via, Claywest’s administrator, that a resident had shown signs of being beaten on more than one occasion. Via feared that she would lose her job if she reported the resident’s beating. Instead, Via advised Kaiser of the incidents and her belief they should be hotlined, and he instructed her not to do so. A survey team leader for the Missouri Division of Aging told Via to call the incidents in to the hotline. Kaiser again reiterated she should not call because he was dealing with a state supervisor who advised it was not necessary. Kaiser and Claywest were convicted for failure to report elder abuse of a resident who was beaten and subsequently died, and the trial court imposed the maximum penalties permitted for such misdemeanor.
The Missouri Court of Appeals affirmed both the convictions and the sentences. The appeals court’s decision included the following conclusions: (1) that Kaiser and AHM were required to report elder abuse under state law, (2) that there was sufficient evidence to support that Kaiser was an accessory to Kia’s failure to report abuse, and (3) that the trial court properly admitted evidence of prior deficiency reports. For these and other reasons, the appeals court upheld defendants’ convictions. Missouri v. Kaiser, Nos. ED82515, ED82516, ED82517, 2004 WL 727030 (Mo. Ct. App. Apr. 6, 2004).

This case demonstrates that an administrator’s policies toward non-reporting can support a conviction for failure to report elder abuse.

DAB Rules That Procedural Irregularities Do Not Negate CMS’ Findings
As the result of several surveys conducted in 1999, the Centers for Medicare and Medicaid Services (CMS) determined that Beechwood Sanitarium was out of compliance with federal participation requirements. CMS imposed a directed plan of correction and a denial of payment for new admissions, and eventually terminated Beechwood’s participation in Medicare. At a hearing, an administrative law judge (ALJ) made several findings: (1) that he had no authority to hear constitutional challenges, (2) that CMS is not required to use reasonable time frames to evaluate a facility’s performance before termination, (3) irregularities in CMS’ notices do not invalidate findings, and (4) he had no jurisdiction to hear arguments regarding the survey in which a directed plan of correction was imposed because the remedy was state-imposed, not federal.

The Departmental Appeals Board (DAB) upheld the ALJ’s determination that the remedies imposed were appropriate. Beechwood Sanitarium v. Centers for Medicare and Medicaid Servs., Dec. No. 1906 (Dep’t Health and Human Servs. Dep’t Appeals Bd. Jan. 23, 2004).

This case demonstrates that ALJs have no authority to hear constitutional challenges and that certain irregularities in CMS notices may not invalidate findings.

California High Court Holds Healthcare Providers Who Abuse Residents Are Not Protected by Professional Negligence Statute Requirements
Plaintiffs, the children of decedent, sued the skilled nursing facility where their father had resided, alleging elder abuse. Defendants opposed plaintiffs’ motion to amend, arguing that the motion was untimely under California’s professional negligence statute Cal. Code Civ. P. § 425.13(a), which establishes procedural requirements in actions for damages arising from a healthcare provider’s negligence. The trial court permitted the amended complaint, and defendants appealed. Because of a conflict among district courts of appeal as to whether such actions fell under § 425.13(a), the state’s high court took jurisdiction.
The California Supreme Court held that the limitations of § 425.13(a) did not protect healthcare providers from the state’s Elder Abuse Law. In so holding, the appeals court found nothing in either § 425.13(a) or the Elder Abuse Law “to suggest the Legislature intended to afford health care providers that act as elder custodians, and that egregiously abuse the elders in their custody, the special protections against exemplary damages they enjoy when accused of negligence in providing health care.”

**Covenant Care Inc. v. Superior Court**, 11 Cal.Rptr.3d 222 (Cal. 2004).

Procedural limitations put in place to protect healthcare providers in negligence actions do not extend to actions under the California elder abuse law.

**Ninth Circuit Rules That California Statute Precluding Medicaid Providers from Using State Funds to Advocate for or Against Union Organization Is Illegal**

In 2000, the California legislature enacted a statute that precluded Medicaid providers who received in excess of $10,000 from using such funding in labor union organization drives. Under the statute, an employer would be required to attest that the funds were not so used, as well as to maintain adequate books and records to audit their use. This statute put employers at a disadvantage when a drive was ongoing. A violation of the statute could result in fines, enhanced CMP’s, and forfeiture of state funds. The U.S. Chamber of Commerce and others (collectively “plaintiffs”) challenged the validity of the statute, seeking declaratory and punitive relief. A district court granted partial summary judgment in favor of plaintiffs, finding that the National Labor Relations Act (NLRA) pre-empted certain provisions of the statutes. Defendants appealed.

The Ninth Circuit affirmed, holding that the California statute was pre-empted by the NLRA and was illegal and unenforceable. The appeals court noted that the provisions were “regulations” and thus were not protected by the market participant exception to NLRA pre-emption. Furthermore, the appeals court found that the statute impermissibly interfered with processes that the NLRA meant to leave free from regulation.

**Chamber of Commerce v. Lockyer**, 364 F.3d 1154 (9th Cir. 2004).

*This case demonstrates that federal law pre-empts a state law that interferes with the intentions of the NLRA.*

**Florida Trial Court Takes Unusual Action to Keep Patient Alive**

In a highly unusual step that may have reached as far as the Vatican, Florida Governor Jeb Bush stepped into a court case and took action to keep Terri Schiavo alive. Schiavo suffered a chemical imbalance in 1990 and has been in a persistent vegetative state ever since.

Florida law permits withdrawal of a feeding tube when (1) a person is in a persistent vegetative state and (2) evidence exists that withdrawal would have been her wish. Schiavo’s husband has waged a legal battle to have his wife’s feeding tube removed, while her parents have maintained an equally adamant battle against removal. The courts have consistently sided with the husband’s position; however, further appeals
have stayed the removal of the tube. In October, an order was issued permitting the husband to have the doctors remove the tube. They did so, however, Governor Bush interjected himself into the foray by seeking a law allowing him to order reinstatement of the tube. The Florida legislature obliged the Governor with a bill (Terri’s Law), and the tube was replaced.

Schiavo’s husband filed suit, alleging that Terri’s Law was unconstitutional. A Pinellas County Judge agreed, and the decision is under appeal. In early May, the Second District Court of Appeal indicated that it wished the case expedited to the Florida Supreme Court. Whether the Supreme Court will hear the case is still pending.

In a strange twist, Pope John Paul issued a statement that removal of feeding tubes is not permissible for Catholics. Several commentators have stated that they believe he is responding to Schiavo’s situation.


This case is important because any decision by an appellate court will surely include a discussion of the separation of powers’ doctrine, as well as the right to personal autonomy. However, Terri’s Law is so narrowly written that it impacts only Schiavo.

Civil Remedies Division ALJ Says Medicare Regulations Do Not Require Opportunity to Correct Deficiency Prior to Imposition of CMPs
The administrative law judge (ALJ) found that nothing in the Medicare regulations guarantees that a skilled nursing facility (SNF) must be afforded the opportunity to correct a deficiency prior to imposing a civil monetary penalty (CMP). In this case, sanctions were imposed on a SNF for failing to supervise a resident who eloped on two separate occasions. After instituting an investigation of the facility following the resident’s first elopement, the facility was given a deadline for correcting the deficiency. Prior to the deadline expiring, the resident eloped again, resulting in the imposition of CMPs for failure to provide proper supervision. The ALJ found the facility out of compliance because it was not “doing everything in its power to prevent accidents.” The ALJ found that a facility that is not in substantial compliance is not entitled to an opportunity to correct. Penalties can be imposed at any time there is noncompliance with program participation requirements, regardless of any deadline to correct a previously detected deficiency.


This case establishes CMS’s long held position that compliance is a continuous requirement. Despite the belief of some providers, no provision in the statute or regulations guarantees an opportunity to correct deficiencies prior to a remedy being imposed.
Sixth Circuit Upholds CMPs Based on Immediate-Jeopardy-Level Violation

Civil monetary penalties imposed on a long term care facility that housed mentally disturbed residents were upheld on appeal, as the Sixth Circuit found that the level of care provided to the residents amounted to an immediate jeopardy level violation. During the course of a survey, surveyors found the facility failed to prevent one resident’s continued escape, and remedial measures were not promptly instituted. Although an alarm was installed on the fence surrounding the facility, it was not operational for nearly a month due to a lack of staff training on how to operate the alarm. Furthermore, the resident was violent toward other residents, including causing a scalp laceration to his roommate. Other residents also escaped from the facility, and there were numerous other violent incidents among the residents at the facility. The appeals court upheld the finding that the facility placed residents in immediate jeopardy of serious or imminent injury or harm. The court also rejected the facility’s claim that it could not be liable for intentional acts of the residents that could not be foreseen, but rather only for accidents. Furthermore, the appeals court noted that the facility was not being held to a strict negligence standard and could potentially be classified as negligent.


This case underscores a debate between nursing facility providers and CMS about what the proper standard of liability should be, especially in the areas of falls, abuse and neglect, and elopement. Facilities argue CMS’s survey interpretations amount to strict liability and a requirement that the facility be a guarantor of resident safety. As a Circuit Court of Appeals case, it counsels that CMS’s position will likely receive deference from the courts, and any appeal needs to have extremely compelling facts.

Tennessee Appeals Court Finds Arbitration Clause Unconscionable and Thus Unenforceable

The case arose out of a challenge by plaintiff, who was executor of his wife’s estate. After his wife passed away at a facility, plaintiff filed the underlying negligence and abuse and neglect lawsuit. Upon admission to the facility, plaintiff had signed the admission agreement for his wife, which contained a binding arbitration/mediation clause. The Tennessee Court of Appeals refused to compel the enforcement of the arbitration and mediation clause. In so doing, the appeals court applied the factors outlined in Buraczynski v. Eyring, 919 S.W.2d 314 (Tenn. 1996), upheld an arbitration clause in a medical malpractice case. Even though the Buraczynski court found the contract to be adhesive, it held that enforceability “generally depends upon whether the terms of the contract are beyond the reasonable expectations of an ordinary person, or oppressive or unconscionable.” In the instant case, the appeals court held that the contract was unconscionable, and therefore unenforceable. The justices in the case relied on a number of facts unfavorable to the facility to reach its decision. Those facts included (1) the clause was “buried” on page ten of the eleven-page contract and was in the same type as the rest of the contract, (2) the clause did not clearly advise plaintiff that
he was giving up his wife’s right to a jury trial, (3) the facility admissions coordinator explained the clause to plaintiff, rather than reading it to him and/or letting him read it himself, and (4) plaintiff could not read or write.


*This case highlights the need for prudence in drafting and using arbitration clauses and provides a useable list of factors that at least one court would find persuasive in choosing to enforce an arbitration clause.*

**Tennessee Appeals Court Declines to Enforce Arbitration Agreement Signed by Spouse of Resident Who Was Not Mentally Incompetent**
The recent case of *Raiteri ex rel. Cox v. NHC Healthcare/Knoxville, Inc.*, illustrates a common problem facilities face in using arbitration clauses: making sure the person signing the clause has the proper authority to do so. In this case, the Tennessee Court of Appeals suggests that the burden is on a facility to establish a reasonable basis as to why an individual other than the patient signs an arbitration agreement to bind the resident. The resident’s husband signed the admission agreement at issue, even though the resident was not diagnosed or adjudicated as mentally incompetent and was “fine mentally” and “very competent.” As a result, the appeals court held that the arbitration agreement was not enforceable because the resident’s husband “did not have the actual or apparent authority to bind [his wife] to the alternative dispute resolution provisions in the admission agreement.” It is important to note that the resident in *Raiteri* was undisputedly competent and able to make her own decisions. The appeals court seemed to leave the door open for the signature of an agent in the case of a patient who could not make his or her own decisions.


*This case highlights the need for attorneys to address the issue of non-patients signing arbitration clauses. Counsel needs to ensure that a mechanism exists identify the proper legal parties to the agreement, and to make sure the patient or those proper parties sign and are bound to the agreements. They should also document clearly that a patient is unable to sign such an agreement if a surrogate party signs the agreement.*

**Third Circuit Says That, Under Olmstead, State Must Detail Plan That Shows It Is Taking All Reasonable Steps to Continue Progress Toward Deinstitutionalization**

A class of mental health patients institutionalized in a state hospital, who are qualified for and desire community placement, sought declaratory and injunctive relief for a more accelerated program of deinstitutionalization. In defending the case, the Commonwealth of Pennsylvania asserted the affirmative defense that the relief requested by plaintiffs would be a “fundamental alteration” of the state’s program and therefore was not required by the Americans with Disabilities Act (ADA).
The Third Circuit ruled against the state, holding that it must do more to demonstrate that it has a community placement plan for about 100 individuals with mental disabilities who remain inappropriately institutionalized. Notably, the appeals court’s opinion rejects the notion that the state’s past progress in developing community placements, coupled with current fiscal constraints, established sufficient evidence of a so-called “Olmstead” plan to relieve it of any further obligation. See Olmstead v. L.C. ex rel. Zimring, 119 S. Ct. 2176 (1999). Acknowledging that at least one-third of the residents no longer require institutional care, the appeals court concluded that, under its reading of Olmstead Pennsylvania “must be prepared to make a commitment to action in a manner for which it can be held accountable by the courts.” Even though the appeals court accepted much of the state’s argument that courts should not be involved in evaluating the adequacy and allocation of the state’s budgetary resources, especially when they are limited due to fiscal constraints, the court still found that overall, state fiscal constraints cannot by themselves establish a fundamental alteration. The appeals court held that the state must detail a plan that evidences “Pennsylvania is taking all reasonable steps to continue progress toward community placement.”


This case a signal to states, especially in the Third Circuit, that while states have broad discretion to make budgetary decisions, courts are not finding that current fiscal constraints are enough to establish a fundamental alteration. It also establishes the acceptance by the courts that the Olmstead language suggesting that states have a “comprehensive working plan” for community placement is now being seen as a de facto requirement on states and their health programs.
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I. PUBLIC HEALTHCARE ENTITIES

California Appeals Court Rejects Physicians’ Claim to Be Placed Back on Corrections Department’s Call List

Madera Community Hospital (MCH) contracted with the State Department of Corrections (DOC) to provide certain health services for inmates. MCH, in turn, entered into service contracts with members of its medical staff to fulfill its contract with DOC. The DOC reimbursed the physicians handsomely. After three months, several physicians noticed that they were no longer receiving referrals and discovered that they had been removed from the call list. The physicians demanded to be placed back on the list, to no avail. The physicians sued MCH for monetary damages on a breach of contract theory, claiming the hospital failed to equally distribute on-call duties for the DOC even though the contract did not address the issue. The physicians alleged that equal distribution was implied in their contracts because of the fact that, under the medical staff bylaws, the hospital placed physicians on a call rotation equally for general on-call emergency room responsibilities. The trial court granted summary judgment in favor of MCH.

The California Court of Appeal affirmed and rejected the physicians’ argument that an implied term existed. The appeals court noted that MCH had never agreed to create the call schedule and that the bylaws required the medical staff to prepare the on-call lists and they alone assigned physicians to that schedule on an equal basis.


The court declined to find an implied contractual term regarding the hospital’s on-call list.

Tennessee High Court Says Public Hospital Has Right to Close Imaging Department, and Radiologists Have No Recourse

A Tennessee public hospital sought to close its imaging department after radiologists on its medical staff sought and received, over the hospital’s objection, a certificate of need to open its own outpatient diagnostic imaging center to compete with the hospital. The medical staff bylaws contemplated exclusive contracting with a provision that allowed medical staff input into such decisions. The hospital filed an action against its radiologists, seeking a declaration that the hospital had the right to close the imaging department by means of an exclusive contract under the statute governing public hospitals. The radiologists counterclaimed to prevent their exclusion from the imaging department and argued that the decision was made in retaliation against the radiologists.
The Tennessee Supreme Court held that the public hospital was authorized to close the imaging department under the applicable statute. With respect to the counterclaims of the radiologists, the supreme court held the radiologists’ loss of clinical privileges resulting from the execution of an exclusive contract does not constitute the reduction, suspension, or revocation of clinical privileges for the purposes of the fair hearing plan in the bylaws. Therefore, the radiologists were not entitled to a hearing. As for the constitutional due process counterclaim, the court held that the hospital’s action did not violate procedural due process given the court’s holding that the bylaws did not afford the radiologists a hearing and clearly contemplated exclusive contracting. The supreme court further held that substantive due process protections were not triggered when due process would not serve any useful purpose. Because the decision to close the department was a business decision, a due process hearing would be purposeless. The radiologists had no property interest entitling them to due process given their professional competence was not questioned.

City of Cookeville v. Humphrey, 126 S.W.3d 897 (Tenn. 2004).

This case illustrates that, when a physician’s professional competency is not at issue and the hospital’s action is a business decision, there is no property interest for due process to protect.

II. PRIVATE HEALTHCARE ENTITIES

Arkansas Trial Court Issues TRO Enjoining Hospital System from Denying Reappointment to Six Cardiologists Based on Economic Conflict of Interest Policy

Cardiologists with an ownership interest in a specialty heart hospital challenged the economic conflict-of-interest policy of the nonprofit hospital system at which they held privileges. The policy mandated the denial of reappointment to any practitioner who directly or indirectly holds an ownership interest in a competing hospital. The cardiologists claimed that the policy violated the federal Anti-Kickback Statute and several Arkansas statutes, and interfered with their professional relationships with their patients. The system moved to dismiss the federal suit for lack of subject matter jurisdiction, as plaintiffs conceded the federal statute provided no private right of action. The federal court dismissed the lawsuit for lack of jurisdiction.

The cardiologists filed in state court. The trial court issued a preliminary injunction under Arkansas law, enjoining the hospital system from applying the policy as the trial court found that it “appears likely that the plaintiffs will ultimately prevail.” It remains to be seen whether the hospital system will appeal this preliminary decision.


This case is one of several demonstrating the current conflict between many hospitals and physicians over the use of economic credentialing by hospitals.
Idaho Supreme Court Upholds Hospital’s Use of Applicant’s Reputation of Disruptiveness to Deny Appointment
The Supreme Court of Idaho upheld a judgment under Idaho law in favor of a private hospital that refused to grant medical staff appointment to a physician with a long history of disruptive behavior. The hospital discovered the applicant’s disruptive tendencies through a series of telephone calls to the physician’s previous practice sites. After a long process, including a hearing and appeal, the hospital denied the physician’s application, finding that his behavior would likely interfere with hospital operations and patient care. The physician sued, alleging that the hospital breached the bylaws and denied him due process by failing to consider his current competency and clinical judgment and failing to disclose the credentialing committee chairman’s telephone notes memorializing the conversations. The trial court ruled in favor of the hospital.

The Supreme Court of Idaho affirmed. First, although not argued, the supreme court held that medical staff bylaws do not constitute a contract between a hospital and its medical staff applicants and appointees. The court went on to hold that judicial review of privilege decisions “is limited to determining whether the procedures adopted by the Hospital afforded each applicant due process, whether the procedures included the requirements set forth in [Idaho law], and whether the Hospital substantially followed its procedures when considering [the physician’s] application for staff privileges.” The court held that the hospital had provided due process and followed the procedures set forth in its bylaws. The applicant was not entitled to discovery of the chairman’s notes and the weight given by the hospital to the various qualification factors is not subject to judicial review.


This case illustrates that a hospital may deny appointment to a competent physician with a history of disruptive behavior so long as the bylaws are followed.

III. PEER REVIEW PRIVILEGE

Michigan Appeals Court Says Physician Suing Hospital’s Attorney for Legal Malpractice Is Not Entitled to Discover Attorney-Client or Peer Review Communications
A physician who was suspended from the medical staff of a hospital sued the attorneys who provided legal representation to the hospital for legal malpractice. The physician’s legal malpractice claim was premised on the fact that one of the hospital’s attorneys had provided the physician legal services in the past. The trial court held that the physician failed to state a claim for legal malpractice and that there was no genuine issue of material fact because all evidence necessary to support the claims was barred from discovery by the peer review privilege and the attorney-client privilege. The physician appealed.
The Michigan Court of Appeals held that the physician sought information obtained by a peer review committee pursuant to its peer review function. Accordingly, the privilege applied and the hospital had not waived it. The appeals court also agreed with the trial court that any confidential communications between the hospital’s attorneys and the hospital pertaining to the attorneys’ representation of the hospital was protected from discovery under the attorney-client privilege. The appeals court affirmed the dismissal of the physician’s claims for tortious interference with a business relationship and legal malpractice. The physician did not provide any evidence that his suspension or the hospital’s refusal to buy his practice would not have taken place if different attorneys with no knowledge of plaintiff had been employed by the hospital as legal counsel.


*This case demonstrates the difficulty that plaintiffs will have in attempting to seek information relating to a peer review committee’s actions relating to its peer review function.*

**IV. HEALTH CARE QUALITY IMPROVEMENT ACT**

**Georgia Appeals Court Holds Agreement Between Physician and Hospital to Avoid National Practitioner Data Bank Violates Public Policy**

An anesthesiologist who admittedly had a history of sexual harassment of nurses and female patients voluntarily resigned and entered an impaired physician treatment program. Over a year later, the anesthesiologist and his psychiatrist, who specialized in “physician sexual behavior disorders,” developed a plan for the anesthesiologist to return to the medical staff and submitted it to the Medical Executive Committee (MEC). After months of consideration, the hospital allowed the anesthesiologist to return with certain conditions and warned that any failure to abide with the plan could result in “suspension, termination or restriction of your clinical privileges.” At reappointment time, the MEC learned that the anesthesiologist had not complied with the plan and recommended denial of reappointment. After a hearing, the MEC revised its recommendation to allow reappointment for a three-month period, but the Board voted to deny reappointment. The Board afforded the physician another hearing. The second hearing panel recommended denial and, after appellate proceedings, the Board denied the application.

The anesthesiologist sued the hospital on various theories, including breach of an agreement not to report him to the National Practitioner Data Bank (“NPDB”). The Court of Appeals of Georgia affirmed the trial court’s dismissal of all the claims by finding the hospital to be immune under the Health Care Quality Improvement Act (HCQIA) and Georgia’s peer review statute. With respect to the claim relating to the NPDB report, the appeals court held that any promise not to report a physician to the NPDB is unenforceable and void because such an agreement violates public policy and federal law.

This case reminds us that agreements crafted to avoid reports to the National Practitioner Data Bank are unenforceable and against public policy.

D.C. Court Says Hospital Is Entitled to HCQIA Immunity When Physician Fails to Comply with Conditions Placed on His Privileges After a Hearing and Appeal
A hospital hearing committee upheld concerns raised about plaintiff surgeon’s care. The hospital appeals committee was persuaded that the cases giving rise to the concerns regarding plaintiff involved very sick patients with complex medical pictures, and recommended that the hearing committee develop a compliance program with record-keeping requirements for the surgeon. The appeals committee noted that non-compliance would result in an automatic termination. Not less than a year later, plaintiff had become severely delinquent in maintaining his patients’ records. The hearing committee asked plaintiff to show cause why his privileges should not be revoked. The second hearing committee recommended to the appeals committee that the surgeon’s privileges be automatically terminated.

The surgeon sued, alleging breach of contract against the hospital and other claims. Plaintiff alleged that the hospital failed to follow medical staff bylaws. The trial court granted summary judgment to the hospital under the Health Care Quality Improvement Act because the facts of the case met the four-prong test for the rebuttable presumption of immunity.

This case demonstrates the difficulty a physician might have in attempting to rebut the presumption of immunity set forth in the HCQIA.

V. DEFAMATION IN THE PEER REVIEW PROCESS

Kentucky Appeals Court Finds Former Staff Member’s Defamation Claim Defeated by His Signed Releases to Allow the Disclosure
Plaintiff, an orthopedic surgeon, developed a bacterial infection on his arm. Although plaintiff immediately ceased performing surgeries until noninfectious, patients complained that they were infected. Around the same time, members of the medical staff complained that the surgeon responded slowly to emergency room calls and transferred patients who could have been treated locally. The medical executive committee (MEC) of Pikeville United Methodist Hospital (PMH) investigated the infection rates and the emergency room concerns, and notified plaintiff in a letter that it recommended additional training and monitoring. Plaintiff immediately resigned. When seeking privileges at two other hospitals, plaintiff signed releases authorizing the disclosure of information from PMH and other hospitals. In response to the inquiries, PMH sent the hospitals a copy of the MEC’s letter to plaintiff. Plaintiff was granted privileges at one hospital, but the other denied his application. Plaintiff filed suit
against PMH for defamation. The trial court granted PMH summary judgment, and plaintiff appealed.

The Court of Appeals of Kentucky affirmed. The appeals court held that PMH was provided with a complete defense regardless of the presence or absence of good faith on the affirmative defense of consent, noting that plaintiff knew the exact contents of the MEC letter and had expressly signed a written release authorizing PMH to release information.


*This case provides additional comfort to hospitals that candidly respond to inquiries for physician information from other healthcare entities.*

**VI. EXCLUSIVE ARRANGEMENTS**

**Tennessee High Court Says Public Hospital Has Right to Close Imaging Department, and Radiologists Have No Recourse**

A Tennessee public hospital sought to close its imaging department after radiologists on its medical staff sought and received, over the hospital’s objection, a certificate of need to open its own outpatient diagnostic imaging center to compete with the hospital. The medical staff bylaws contemplated exclusive contracting with a provision that allowed medical staff input into such decisions. The hospital filed an action against its radiologists, seeking a declaration that the hospital had the right to close the imaging department by means of an exclusive contract under the statute governing public hospitals. The radiologists counterclaimed to prevent their exclusion from the imaging department and argued that the decision was made in retaliation against the radiologists.

The Tennessee Supreme Court held that the public hospital was authorized to close the imaging department under the applicable statute. With respect to the counterclaims of the radiologists, the supreme court held the radiologists’ loss of clinical privileges resulting from the execution of an exclusive contract does not constitute the reduction, suspension, or revocation of clinical privileges for the purposes of the fair hearing plan in the bylaws. Therefore, the radiologists were not entitled to a hearing. As for the constitutional due process counterclaim, the court held that the hospital’s action did not violate procedural due process given the court’s holding that the bylaws did not afford the radiologists a hearing and clearly contemplated exclusive contracting. The supreme court further held that substantive due process protections were not triggered when due process would not serve any useful purpose. Because the decision to close the department was a business decision, a due process hearing would be purposeless. The radiologists had no property interest entitling them to due process given their professional competence was not questioned.

**City of Cookeville v. Humphrey**, 126 S.W.3d 897 (Tenn. 2004).
This case illustrates that, when a physician’s professional competency is not at issue and the hospital’s action is a business decision, there is no property interest for due process to protect.

VII. SUSPENSIONS

New Jersey Appeals Court Holds That Reinstated Physician Is Unable to Obtain Monetary Relief for Income Loss During Suspension
The medical executive committee of the hospital suspended plaintiff physician’s medical staff privileges. After a fair hearing pursuant to the bylaws, plaintiff was reinstated and later filed a lawsuit seeking monetary damages resulting from his temporary suspension. The Superior Court of New Jersey held that, in cases involving a hospital’s decision regarding privileges, the judicial remedy is limited to assurance of a fair proceeding in determining those decisions. Accordingly, the trial court granted summary judgment in favor of the hospital and dismissed the physician’s complaint for damages.

Wisconsin High Court Finds No Due Process Right to Out-of-State Counsel in Peer Review Proceeding and Declines to Create Exception Allowing Out-of-State Attorney to Represent Physician in Peer Review Hearing
A suspended physician sought a declaration from the court that he had the right to representation by his out-of-state attorney, who also held a medical degree, in the peer review hearing. In the alternative, the out-of-state attorney filed a petition pro hac vice. The trial court denied the requests. On appeal, the Supreme Court of Wisconsin affirmed the denial of the physician’s motion for a declaratory judgment and the attorney’s motion to be admitted pro hac vice, and held that the words “legal counsel” as used in the medical staff bylaws mandated that the attorney representing the physician be licensed to practice law in Wisconsin. The high court stated that the bylaws constituted a contract and that a reasonable person would understand that “legal counsel” refers to an attorney licensed in Wisconsin. The high court also affirmed the denial of the request for the attorney be admitted pro hac vice because the state’s supreme court rules only allow a judge to admit an attorney for an appearance in his or her court and only to participate in association with an active member of the Wisconsin bar.
Seitzinger v. Community Health Network, 676 N.W.2d 426 (Wis. 2004).

This case highlights an interesting issue that medical staffs and hospitals should discuss. Limiting legal counsel to those who practice within the state is a way to maintain control of the hearing process. To avoid a case like this, bylaws should state “an attorney licensed to practice in this state” if that is the intent.
U.S. Court in Pennsylvania Dismisses Antitrust Suit Brought by Physician with Long History of Disruptive Behavior
The physician’s privileges were first suspended in 1992. He was suspended again several years later for, among other actions, making harassing phone calls to patients, criticizing another physician on the medical staff, and screaming obscenities at operating room nurses. Following the second suspension, the physician was reappointed to the medical staff subject to seventeen “Conditions of Reappointment.” Pursuant to the conditions, the physician agreed, among many other things, to refrain from calling patients, to use proper administrative channels for voicing complaints, and to comply with the hospital’s rules and regulations. Soon after reappointment, the physician violated some of the conditions, and his reappointment was revoked. The physician sued on the theory that the hospital’s actions violated the federal antitrust laws. The court disagreed, noting that the physician himself, rather than the hospital caused any detrimental effect resulting from the revocation. As the court stated, “[h]ad the physician not violated the Conditions, he would not have been excluded.” The court also noted that the physician failed to prove other required elements of his various antitrust claims.


This case exhibits the current trend by hospitals to no longer tolerate disruptive physicians.

U.S. Court in Louisiana Denies Temporary Restraining Order and Preliminary Injunction Request of Cardiologist Alleging § 1983 Violation
A cardiologist whose active staff membership was reduced to consulting membership because of patient care concerns sought a temporary restraining order and a preliminary injunction arguing that the hospital’s peer review process was inherently unfair and denied her due process. Specifically, she alleged that the catheterization lab committee, which first identified cases of concern, was composed entirely of her competitors. Plaintiff also alleged that the hearing officer unfairly limited her presentation and therefore she did not have a meaningful opportunity to present her case.

The U.S. District Court for the Eastern District of Louisiana rejected plaintiff’s request for injunctive relief, ruling that she failed to show even some likelihood of success on the merits. The court also rejected plaintiff’s claims regarding the role of her competitors in the peer review process, noting the multiple layers of case review, including two outside reviews and the recusal of those committee members who were her competitors. The court also held the limitations imposed by the hearing officer on the testimony did not deny the cardiologist due process. The hearing officer allowed the cardiologist to present relevant evidence and “cut her off only when he determined that the proffered evidence was irrelevant to the issues before the panel.” The court refused the hospital’s dismissal motion, ruling that, even though plaintiff was unable to show a likelihood of success on the merits, she did state a claim and, viewing the facts in the light most favorable to the cardiologist, the court said it could not conclude that there exists no state of facts to support her claim.

The court found no likelihood that a physician would succeed in her claim of unfair and unconstitutional due process.
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I. ALTERNATIVE DISPUTE RESOLUTION

South Carolina Appeals Court Labels a Physician Recruiting Agreement “Activity Involving Interstate Commerce”

Dr. James Thornton, a cardiovascular surgeon, entered into a recruiting agreement to move his practice from Michigan and join South Carolina Cardiovascular Associates (SCCA) in Charleston, South Carolina. The agreement, which contained a provision for binding arbitration, provided that Thornton would maintain his practice in Charleston for four years and, in return, would receive certain financial guarantees, a signing bonus, relocation expenses, and membership in SCCA. Thornton, who left the practice and relocated before the end of his four-year commitment, brought a declaratory judgment action requesting a determination that the recruiting agreement’s arbitration provision was unenforceable under state law. Reversing the lower court’s decision, the South Carolina Court of Appeals held that the arbitration clause was enforceable because the recruiting agreement involved interstate commerce, and the Federal Arbitration Act governs and pre-empts state law. The appeals court determined that the agreement was an “activity involving interstate commerce” because it involved a monetary inducement to move from one state to another and that move was an essential element of the agreement.


This case illustrates how important it is for physicians to be aware that entering into a contract that induces them to relocate a practice from one state to another involves interstate commerce. Such agreements may subject physicians to lesser protection than is provided for under more stringent state laws dealing with contractual arrangements.

II. ANTITRUST ISSUES

Alabama Supreme Court Holds That Public Hospital’s Exclusive Contract for Oncology Services Was Not Antitrust Violation

The Alabama Supreme Court held that an exclusive agreement between DCH Healthcare Authority, Inc. (DCH), a public hospital corporation, and Oncology Associates of West Alabama, P.C. (OA), to provide inpatient and outpatient oncology services at DCH facilities was not a violation of state antitrust laws. The case arose when Southeast Cancer Network, P.C. (SCN), sued DCH and OA for interference with a business relationship and for engaging in an unlawful trust, combine, or monopoly in violation of state antitrust laws. DCH granted SCN general privileges at its facilities, but refused to grant SCN special staff privileges to practice oncology. The high court explained that OA’s exclusive agreement with DCH did not restrain other physicians from working as oncologists, but merely denied staff privileges in oncology at medical facilities.
facilities operated by DCH. The high court noted that SCN had at least thirty other hospitals in which it could practice oncology and DCH granted SCN staff privileges in other areas of medicine.


This case illustrates that hospitals can enter into exclusive agreements with physician groups without violating antitrust laws, especially in circumstances in which other physician groups have alternative practice site options and are not completely barred from practicing at the hospital.

FTC Cites Medical Group for Price Collusion
The Federal Trade Commission (FTC) issued a complaint against California Pacific Medical Group, doing business as Brown & Toland Medical Group, alleging price fixing in connection with preferred provider organization (PPO) contracts. The complaint asserted that Brown & Toland had unlawfully negotiated PPO contracts with health plans on behalf of its member physicians by organizing horizontal contracts under which its competing member physicians collectively agreed on the price and other competitively significant terms on which they would enter into contracts with health plans or other third-party payers. According to the FTC, Brown & Toland directed its physicians to end pre-existing contracts with payers, required its physician members to charge specified prices in all PPO contracts, and approached other physicians’ organizations to invite them to enter into similar price fixing arrangements. The FTC sought a cease and desist order to bar the activity and nullify all existing contracts already negotiated by the group with health plans and third-party payers.


This case is important because it signifies the FTC’s increasing interest in how physician groups negotiate with payers. Interestingly, it is the first complaint issued by the FTC in a physician price-fixing case that has not been accompanied by a consent agreement. See also In re Washington University Physician Network, FTC No. 021 0188 (July 11, 2003) (in which the FTC settled price-fixing charges against a physician network issuing a consent order in which the network was prohibited from negotiating with payers on any physician behalf; dealing, refusing to deal or threatening not deal with payers; determining what terms to deal with any payer; or refraining to deal individually with any payer), and In re Physician Network Consulting LLC, FTC No. 021 0178 (July 22, 2003) (in which the FTC entered into 20-year consent order with Physician Network Consulting dealing with price collusion).

FTC Charges Physician Group with Engaging in Cartel Conduct with Payers
In a complaint against North Texas Specialty Physicians (NTSP), the Federal Trade Commission (FTC) charged the group with participating in illegal polling practices. According to the complaint, NTSP polls participating physicians to determine the minimum fee they would accept for medical services provided pursuant to an NTSP-payer agreement. After obtaining this information, NTSP calculates the averages and
reports these measures to its participating physicians. The FTC asserted that this exchange of prospective price information among physicians who otherwise are competitors would have the effect of reducing price competition. *In re North Tex. Specialty Physicians*, No. 9312 (Fed. Trade Comm’n Sept. 17, 2003). The complaint is available at http://www.ftc.gov/os/2003/09/ntexasphysiciancomp.pdf

This action by the FTC again illustrates the agency’s concern with how physician groups negotiate prices with payers and that the stifling of price competition will not be tolerated.

### III. CONTRACT ISSUES

**Connecticut High Court Finds Minors Liable for Payment for Emergency Services Under Doctrine of Necessaries**

The Connecticut Supreme Court has ruled that a minor’s estate was liable for payment for emergency medical services provided to the minor. The supreme court reviewed the common law “doctrine of necessaries,” an exception to the general rule that contracts with minors are voidable. The doctrine provides that a minor may not avoid contracts for goods or services necessary for the minor’s health and sustenance. The supreme court explained that when a medical service provider renders necessary medical care to an injured minor, two contracts arise: the primary contract between the provider and the minor’s parents, and an implied-in-law contract between the provider and the minor. The supreme court noted that the provider of necessaries must make all reasonable efforts to collect from the parents before resorting to the secondary, implied-in-law contract with the minor. *Yale Diagnostic Radiology v. Fountain*, 838 A.2d 179 (Conn. 2004).

This case helps in increasing the ability of physicians to recover fees associated with the emergency care of a minor.

### IV. EMPLOYMENT ISSUES

**U.S. Supreme Court Says Treating Physician Rule Does Not Apply to ERISA Disability**

The U.S. Supreme Court unanimously held that ERISA does not require special deference for a treating physician’s opinion or impose a burden on a health plan administrator to explain the rejections of a treating physician’s opinion. In reaching this decision, the Court vacated and remanded a Ninth Circuit judgment, explaining that the “treating physician rule” was developed to control Social Security disability determinations and was formally adopted by the Commissioner of Social Security; however the rule was not adopted by the Secretary of Labor who ERISA directs to promulgate regulations to carry out the Act’s provisions. The Court concluded that the plain language of ERISA requires a reasonable opportunity for a fair review of a
denial, but administrators are not required to give special weight to a treating physician’s opinion. 


This case is important because the Supreme Court settles in the negative the question of whether the “treating physician” rule applies to ERISA, and notes that ERISA still affords procedural due process to patients even without applying the “treating physician” rule.

Georgia Appeals Court Applies Minimal Scrutiny to Non-compete Agreement Entered into in Connection with Sale of Business

The Georgia Appeals Court considered whether a physician violated a non-compete agreement with a partnership that leased lithotripsy equipment by investing in a company that also leased this equipment. The court grappled with the issue of what level of scrutiny to apply to the Agreement. The court noted that restrictive covenants in connection with the sale of a business are given minimal scrutiny, while covenants not to compete as part of an employment contract are given a high level of scrutiny. The partnership argued that the agreement in the instant case was entered into in connection with the sale of a business and so should be reviewed with a lesser degree of scrutiny. Alternatively, the physician argued that the agreement should be viewed in the context of a professional partnership agreement. The court disagreed with the physician and held that the agreement should be viewed with minimal scrutiny because the agreement was entered into in connection with a sale of business because the physician did not practice medicine with the partnership and benefited through his passive investment.


This case illustrates how Georgia courts view non-compete agreements, with less protection being afforded to physicians who enter into non-compete agreements related to the sale of a business.

North Carolina Appeals Court Says Jury Must Address Whether Medical Practice Violated COBRA

Plaintiff, a pediatrician, brought a wrongful termination of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and breach of contract claim against a pediatric medical group. On April 17, 2000, plaintiff was terminated after the pediatric medical group learned of her plans to open a practice of her own. Plaintiff’s termination was effective immediately, and termination of her health insurance coverage under the pediatric medical group health plan was effective May 1, 2000. Reversing the trial court’s directed verdict, the North Carolina Court of Appeals held that plaintiff’s COBRA-related claim and breach of contract claim presented questions for a jury. The appeals court noted that the parties were in dispute as to whether defendant’s workforce was sufficient to require its compliance with COBRA. Additionally, the appeals court noted that a question remained as to whether plaintiff’s termination was not a qualifying event under COBRA.

This case illustrates that physician and physician groups should become aware of the implications of COBRA as it relates to a termination of employment.

Sixth Circuit Holds That Independent Contractors Cannot Bring Employment Discrimination Suits
Dr. Bhanukumar C. Shah, a general surgeon, brought an action against Deaconess Hospital alleging age and national origin discrimination. In 1999, Deaconess had revoked part of Shah’s surgical privileges after one of his patients died following surgery. In his complaint, Shah claimed age discrimination in violation of the Age Discrimination in Employment Act (ADEA), discrimination based on national origin in violation of Title VII of Civil Rights Act of 1964, and discrimination in violation of an Ohio statute.

On appeal and affirming the decision on different grounds, the Sixth Circuit concluded that neither the ADEA, Title VII, nor the Ohio statute protected Shah in his relationship with the hospital. The appeals court explained that Title VII and ADEA allow an employee to bring an action for discrimination, but not an independent contractor. The appeals court noted that the evidence supported the conclusion that Shah was an independent contractor and not an employee because (1) he had admitted that he was not an employee during a deposition, (2) the hospital did not pay him, and (3) Shah performed almost half of his surgeries at other hospitals.


The case is important because it demonstrates that physicians who are independent contractors are not afforded the same protections for employment discrimination as physicians who are employees.

Tennessee Appeals Court Finds Non-compete Agreement Between Clinic and Physician Enforceable
The Tennessee Court of Appeals determined that a contract containing a non-compete clause that prohibited a physician from practicing medicine within a twenty-five mile radius for eighteen months after termination was valid. The appeals court explained that a non-compete clause is valid if (1) there is consideration for the agreement, (2) there is danger to the employer in the absence of the agreement, (3) the employee’s economic hardship is minimal, and (4) the agreement is in the public interest. The court noted that the non-compete provision satisfied the four requirements and was enforceable.


This case illustrates that physicians need to carefully scrutinize non-compete agreements. Less protection is afforded to physicians when there is consideration, danger to employer, and when such agreements support the public’s interest. See also Community Hosp. Group, Inc. v. More, 838 A.2d 472 (N.J. Super. Ct. App. Div. 2003) (finding enforceable a non-compete agreement prohibiting a neurosurgeon from
practicing within a thirty-mile radius for two years after termination of employment because the agreement protected the legitimate interest of the employer, it imposed no undue hardship on the employee, and it was not injurious to the public).

U.S. Court in Iowa Says Physician’s Negotiation over Some Parts of Employment Agreement Belie Adhesiveness of All Other Parts of Agreement

Plaintiff physician entered into an employment agreement with defendant hospital. When the agreement terminated and the parties entered litigation, defendant sought to enforce a jury waiver term set forth in the employment agreement. Plaintiff resisted the jury waiver term, arguing that it had been forced upon her in negotiations in which she had no bargaining power and in which defendant had presented the proposed agreement as a “take it or leave it” “standardized form” proposition.

The U.S. District Court for the Southern District of Iowa held that the lack of negotiation over this specific term did not indicate that the term was non-negotiable and thus invalid. The proper standard for invalidating the agreement, the court explained, is not the mere inequality of the parties’ bargaining power, but, rather, an “inequality that is manifestly or grossly in favor of the proponent of the [agreement].” The court found no such inequality; to the contrary, the court found that the physician was not quite so powerless as she portrayed herself to be, observing the following facts against the physician’s position: the physician and hospital had actually negotiated over and had modified other terms of the proposed agreement, the physician had earlier expressed happiness over the completed agreement, and the physician’s previous employment had involved contract management and negotiation for another medical group. Furthermore, the court noted that, although plaintiff had never used an attorney in this transaction, she had had two weeks in which to consult one before the agreement became effective. Consequently, the court held that plaintiff had voluntarily and knowingly agreed to waive her right to trial by jury.


This case illustrates that a physician’s successful negotiation over any provision in employment agreement negates the conclusion that the physician had insufficient bargaining power to negotiate over other parts of the agreement.

V. FRAUD AND ABUSE ISSUES

DHHS OIG Approves Joint Venture for MRI Facility Between Medical Center and Radiology Group

The Department of Health and Human Services Office of Inspector General (OIG) determined that it would not impose administrative sanctions under the Anti-Kickback Statute regarding a joint venture between a medical center and a radiology group to own and operate an outpatient magnetic resonance imaging (MRI) facility. Although the proposed arrangement did not qualify for protection under the small entity investment safe harbor, the OIG stated that it would not impose administrative
sanctions because the proposed arrangement contained certain safeguards that made the potential risk of fraud and abuse acceptably low. The OIG noted that a low risk of fraud and abuse existed because: (1) the investing radiologist would not be in a position to refer patients of the facility or medical center, (2) the medical center certified that less than 10% of the facility’s referrals would come from the medical center or physicians employed by the medical center, (3) the medical center’s position to influence referrals was mitigated by the medical center’s certification to refrain from and track referrals of affiliated physicians, and (4) the return on investment in the facility would be proportioned to the respective capital investment.


The Advisory Opinion is significant because it offers more guidance from OIG regarding the structuring of joint ventures between physicians and hospitals. See also Advisory Opinion No. 03-13 (Dep’t Health and Human Servs. Office of Inspector Gen. June 16, 2003) (dealing with the approval of a joint venture for a freestanding MRI center located on a rural hospital’s campus), which offers further guidance from the OIG on joint ventures between hospitals and physicians.

**Ninth Circuit Rules That Treble Damages Award Was Not Excessive in False Claims Case**
The United States brought a False Claims Act (FCA) action against Peter Mackby for submitting 8,499 false claims to Medicare between 1992 and 1996. The government sought damages for only 1,459 of those claims. The government was awarded a total $729,459.92 in treble damages and fines, but the total penalty would have been $85 million had the government sought damages on all the claims. The Ninth Circuit, in affirming the lower court’s judgment, held that the penalty was not grossly disproportional to the gravity of Mackby’s offense. The Court based its decision on (1) the fact that Mackby had knowingly filed false claims, (2) the damage to the government caused by false claims undermined public confidence in the system, and (3) the fact that the total penalty would have been $85 million.

**United States v. Mackby,** 339 F.3d 1013 (9th Cir. 2003).

This case illustrates how the government can calculate damages in False Claims Act cases.

**Eleventh Circuit Overturns Physician Conviction in Case in Which Indictment Failed to Allege Fraudulent Scheme**
The Eleventh Circuit dismissed an indictment for healthcare fraud and vacated a physician conviction in a case in which the indictment had failed to allege any fraudulent scheme or conspiracy by the physician. The appeals court explained that the indictment, which made broad allegations of fraud, failed to provide any facts alleging the manner and means by which the alleged scheme to defraud was operated and failed to allege the connection between the alleged fraud and the delivery or payment of healthcare services.

**United States v. Bobo,** 344 F.3d 1076 (11th Cir. 2003).
This case demonstrates that an indictment for healthcare fraud must contain all essential elements or the indictment will fail.

New York Appeals Court Finds “Dean’s Fee” to Be Illegal Fee-Splitting Demand

Drs. Marc and Steven Odrich brought suit against Columbia University when they were denied faculty appointments at its College of Physicians and Surgeons for refusing to pay the University a fee equal to 10% of the fees generated in their private practice. The New York Supreme Court Appellate Division held that the fee violated N.Y. Educ. Law §§ 6530(1) and 6531. The appeals court found that the fee would not violate these provisions if the physicians were employees of the University’s faculty practice plan and the University was providing the employees “salary, employee benefits, facilities, supplies, staff or malpractice coverage.” This ruling upheld the September 2002 trial court decision finding that the imposition of the fee was illegal fee splitting. This case arose when the physicians, who were previously full-time professors and attending physicians at the University or hospitals affiliated with the University (and as such had their reasonable practice expenses, including salaries, rent, overhead, malpractice, paid by the university), decided to resume their part-time relationship with the University and resume a full-time private practice. The university told the physicians that they could continue practicing at the University and remain faculty members if they paid 10% of their practice fee income to change their appointments from a full-time to a part-time basis. Both the court and the trial courts held in favor of the doctors and found the arrangement invalid because the University was requiring the physicians to pay over revenue that was entirely unrelated to any compensation or services paid by the University or its affiliated entities. Odrich v. Trustees of Columbia Univ., 308 A.D.2d 405 (N.Y. App. Div. 2003).

This case is important because it challenges the way academic medical centers, their faculty practice plans, and affiliated medical schools deal with academic appointments and the imposition of fees on physicians who receive or maintain those appointments.

DHHS OIG Approves Reintegration of Medical Group and Hospital into Single Entity

The Department of Health and Human Services Office of Inspector General (OIG) issued an advisory opinion stating that a proposal to reintegrate a medical group and a hospital that were originally a single entity did not violate the Anti-Kickback Statute. The proposal requires the medical group to transfer its assets to the hospital in exchange for the hospital paying all encumbrances related to the transferred assets, up to a present payment cap. The OIG explained that it would not impose administrative sanctions in connection with the arrangement because (1) the proposed transfer flowed in the same direction as the referral pattern, (2) the medical group will mostly see existing patients in the new hospital clinic, and (3) the compensation received by the medical group will be substantially the same as the compensation received before the proposal. Advisory Op. No. 03-15 (Dep't Health and Human Servs. Office of Inspector Gen. December 11, 2003).
This advisory opinion demonstrates that hospitals and physician groups can merge into a single entity and not violate the Anti-Kickback Statute.

Fifth Circuit Holds That Prior Evidence of Physician Misconduct Is Admissible
Dr. James T. Parsons, indicted on twenty-three counts of healthcare fraud, submitted a motion in limine seeking to exclude materials from the Texas State Board of Medical Examiners (Board) concerning a prior violation committed by Parsons. During trial, Parsons based his defense on mistake or accident based on the disorganization of his office and staff. In response to this defense, the trial court allowed the introduction of evidence showing that the Board had warned parsons to adequately supervise his office staff. Rejecting Parsons’ argument that the introduction of this evidence was prejudicial, the Fifth Circuit held that the probative value of evidence related to Parsons’ prior dealing with the Board outweighed prejudice and was properly admitted to rebut the defense of mistake. The appeals court explained that the evidence showed that defendant knew he had a duty to supervise his staff to make sure they were not violation the law.

This case illustrates that prior incidents of fraud and abuse could be used against physicians and are detrimental to the outcome of the case, especially if the physician’s defense calls into question the prior misconduct.

VI. HOSPITAL ISSUES

Florida Appeals Court Says Physician’s Failure to Comply with Financial Responsibility Statute Imposes Liability on Hospital
Plaintiffs sued and obtained a malpractice judgment against Dr. Cesare DiRocco, a physician at Mercy Hospital. DiRocco filed for bankruptcy, and plaintiffs brought separate actions against the hospital, alleging strict liability under Florida’s financial responsibility law and negligence for failure to ensure that DiRocco complied with a state law requiring a physician to comply with one of three financial responsibility options in order to obtain hospital staff privileges. Under this law, a physician must have coverage in the amount of $250,000 per claim by establishing an escrow account, acquiring professional liability insurance, or maintaining a letter of credit. A physician is exempt from the requirements of the statute if the physician agrees to pay any medical malpractice judgment creditor $250,000 of any judgment, informs patients that he or she does not carry medical malpractice insurance, and provides written notification to the Florida Department of Health demonstrating compliance with the statute. The Florida District Court of Appeal concluded that the statute mandates financial responsibility as a condition to maintaining staff privileges and imposes a duty on the hospital to ensure compliance.
This case illustrates that healthcare providers are not immune from liability for physician malpractice, if the provider failed to ensure that the physician met the minimum financial responsibility requirements of the law.

VII. INDIVIDUAL/PATIENT RIGHTS

Wisconsin Appeals Court Holds EMT Liable for Publicizing Patient’s Medical Condition
An emergency medical technician for Tess Corners Volunteer Fire Department, after responding to an emergency 911 call regarding a possible overdose of plaintiff, contacted one of plaintiff’s coworkers and informed the coworker that plaintiff had been taken to the hospital for a possible overdose. Plaintiff sued the technician, the Fire Department, and their insurer (collectively “defendants”) for invasion of privacy under a Wisconsin statute. The Wisconsin Court of Appeals rejected defendants’ argument that the publicity element of the statute required disclosure to more than one person and held that disclosure is not based solely on the number of individuals to whom the disclosure is made, but rather on “the particular facts of the case and the nature of plaintiff’s relationship to the audience who received the information.” The court noted that the technician had disclosed plaintiff’s private information to a person she knew to be plaintiff’s co-worker.


This case illustrates the importance of maintaining patient privacy and confidentiality, even outside of a hospital setting.

California Appeals Court Says Disclosure of General Health Information Is Not Violation of State Disclosure Law
Dr. William Young, after providing medical treatment to plaintiff, informed her employer in general terms about her condition. Plaintiff sued Young for invasion of privacy and violation of the California Confidentiality of Medical Information Act (CMIA). The California Court of Appeal, affirming the decision of the trial court, held that CMIA permits the disclosure of general information about a patient. The court also found that plaintiff had talked about her condition with other coworkers and third parties. The court viewed her disclosures as a waiver of rights in a lawsuit against a medical provider for violation of the CMIA and that plaintiff had no reasonable expectation of privacy about her medical condition.


This case illustrates that a patient can waive his or her privacy rights and that there are circumstances under which a disclosure of medical information by the treating physician does not constitute a violation under privacy laws.
VIII. INSURANCE ISSUES

Ninth Circuit Holds That Supervising Physician Is Treating Source in Determining Disability

Plaintiff had one visit with Dr. Zwiefach, the psychiatrist overseeing her case. Zwiefach diagnosed her with major depression, an unspecified personality disorder, and chronic pain. In determining whether plaintiff was disabled, an administrative law judge (ALJ) did not credit Zwiefach’s mental assessment of plaintiff as her treating physician. Disagreeing with the ALJ and the federal district court, the Ninth Circuit held that a supervising physician could be a treating source in determining whether a claimant is disabled under 20 C.F.R. §§ 404.1520 (a)-(f). Section 404.1502 defines a “treating source” as a “physician, psychologist, or other acceptable medical source” who has an “ongoing treatment relationship” with the claimant and who sees the claimant “with frequency consistent with accepted medical practice for the type of treatment and/or evaluations required for [a] medical condition.” The appeals court conceded that Zwiefach only saw plaintiff once, but explained that other members of the treatment team consisting of non-physicians had sufficient contact with her to qualify unequivocally as a treating source.

Benton v. Barnhart, 331 F.3d 1030 (9th Cir. 2003).

This case illustrates that physicians under the “treating source” rule are not required to continuously see or treat a patient, provided the patient has sufficient contact with other members of the physician’s staff.

Wisconsin Appeals Court Finds Patient Compensation Fund Liable for Damages in Excess of Physician Insurance

Drs. Louis Somberg and several other physicians were found negligent in the treatment death of Mark Capistrant. Negligence was apportioned among the defendants, with Somberg being apportioned the largest percentage of liability (70%), with total damages being assessed of $2.7 million. Somberg was self-insured through his employer for $600,000 per occurrence, and the other defendants were insured for $1 million per occurrence by Physician Insurance Company of Wisconsin. The Wisconsin Patients Compensation Fund (Fund) was directed to pay $2,108,065 to plaintiffs pursuant to a Wisconsin statute providing that anyone who is “found to be causally negligent whose percentage of causal negligence is 51 percent or more shall be jointly and severally liable for the damages allowed.” The Wisconsin Appeals Court ruled that the Fund was liable for the full amount of damages in excess of Somberg’s $600,000 because the Fund stands in the place of those it covers.


This case is important because it illustrates that, in states with contributory negligence statutes, a physician can be responsible for the entire amount of the damages in certain circumstances.
Physicians Endorse Proposal of Single-Payer System
More than 7,500 physicians have endorsed a proposal to provide universal health insurance coverage through a single-payer system. The proposal was created by the Physicians’ Working Group for Single-Payer National Health Insurance. Under the proposal, health insurance programs will pay for the operating costs of hospitals and clinics, physicians will continue to bill on a fee-for-service basis, or receive salaries from group practices, hospitals or clinics, and boards of experts will determine which healthcare services would be covered by national health insurance and which services are unnecessary or ineffective. It is estimated that transitioning to a single-payer system would save at least $200 billion annually on paperwork and administration. More information is available at http://jama.ama-assn.org/cgi/content/full/290/6/798.

This proposal is important because it signals a shift in how physicians are viewing the provision of care in the United States, and how other alternatives (in the physicians’ view) will be necessary to provide universal coverage and control rising healthcare costs.

New Jersey Appeals Court Finds No Duty on Insurance Company to Defend Medical Group in Improper Billing Claim
The Appellate Division of the New Jersey Superior Court has ruled that health insurers are not obligated to provide medical groups they insure a defense in actions involving improper billing for services. Blue Cross/Blue Shield of New Jersey filed a complaint against two medical groups, seeking reimbursement for more than $3 million in health insurance benefits that it alleged were improperly paid. In reaching a decision, the appeals court held that a health provider’s insurer is not required to defend a claim for improper billing because the claim fell outside the policies’ scope. The appeals court explained that the policies afford coverage for injuries arising out of the physician’s providing or failure to provide professional services, all in the context of a medical incident. The appeals court did not consider a claim for reimbursement to represent a medical incident. Hampton Med. Group v. Princeton Ins. Co., 840 A.2d 915 (N.J. Super. Ct. App. Div. 2004).

This case illustrates that insurers are not responsible for defending claims against a physician that involve some form of misconduct not arising from the physician’s provision of services.

IX. MEDICAL MALPRACTICE ISSUES

Texas High Court Says Physician Was Not Liable Under Good Samaritan Statute Because There Was No Expectation of Compensation
The Texas Supreme Court, on an issue of first impression, held that a physician is not liable under the Good Samaritan statute when the physician did not act with the expectation of remuneration. The high court concluded that the physician did not act
with expectation of remuneration because there was an emergency situation and the physician had no duty to respond to the emergency. The court set forth two instances in which a physician has acted with the expectation of remuneration: where a person (1) would ordinarily receive remuneration, or (2) would be entitled to receive remuneration. The case arose out of a malpractice action against a physician who, in responding to an emergency page, was allegedly negligent in delivering a baby. McIntyre v. Ramirez, 109 S.W.3d 741 (Tex. 2003).

This case of first impression in Texas’s high court is important because the court extended further protection to physicians under the Good Samaritan statute, even when a physician is responding in a hospital setting.

U.S. Court in New Hampshire Finds No Vicarious Liability for Independent Contractors
The U.S. District Court for the District of New Hampshire held that a hospital is not vicariously liable for the negligence of independent contractors who lacked actual or apparent authority. The court explained that apparent authority may arise from acts or appearances of a principal that may lead a reasonably prudent person to believe there is an agency relationship between the principal and the alleged agent. The court concluded that the hospital neither performed any act nor maintained any appearances that would give a reasonably prudent person reason to believe that the hospital had vested apparent authority in the independent contractor. The court noted that plaintiff was informed and signed a consent form stating that independent contractors were not employees of the hospital. Ural v. Levy, No. 01-215-B, 2003 WL 21511122 (D.N.H. June 30, 2003).

This case illustrates that when patients are adequately informed about the independent status of physicians, a hospital will not be held vicariously liable for the physicians’ negligence. But see Shands Teaching Hosp. & Clinic Inc. v. Juliana, 863 So.2d 343 (Fla. App. 2003), in which the Florida District Court of Appeals held that the independent contractor rule does not apply with equal force to subcontractors like nurses or technologists who do not bill separately for their services.

Alaska Supreme Court Rejects Malpractice Claim, but Allows Negligent Credentialing Claim
Plaintiffs filed a complaint against Dr. Rene Alvarez and South Peninsula Hospital, claiming negligent diagnosis and treatment by Alvarez and that negligently hiring and granting of hospital privileges by the hospital. The focus of plaintiffs’ negligent credentialing claim was based on South Peninsula’s renewal of Alvarez’s hospital privileges prior to one of the plaintiff’s treatment. Plaintiffs presented evidence that South Peninsula had actual or constructive knowledge of (1) a prior malpractice claim against Alvarez, (2) information indicating that Alvarez’s privileges had been suspended by another hospital, and (3) Alvarez’s lack of malpractice insurance. Based on this evidence, the supreme court determined that South Peninsula had failed to establish as a matter of law that it did not have actual or constructive notice of
Alvarez’s potential negligence and allowed plaintiffs to proceed with the negligent credentialing claim.  

*This case demonstrates that hospital could be held liable for negligent credentialing of a professional, under a vicarious liability theory, despite the dismissal of the underlying malpractice claim.*

**Colorado Supreme Court Allows Malpractice Suit to Go Forward Because of Improper Wording and Typeface in Arbitration Clause**

In a wrongful death action, the Supreme Court of Colorado addressed whether plaintiff is bound by an arbitration provision contained in her deceased husband’s agreement with Kaiser Foundation Health Plan of Colorado (Kaiser). The contract between Kaiser and the deceased contained an arbitration clause requiring “any claim of medical malpractice” to be submitted to binding arbitration. The clause included claims for “death” asserted by “a Member’s heir or personal representative.” The high court found that the arbitration agreement was valid, but failed to meet the prescribed wording and typeface requirements of the Colorado’s Health Care Availability Act, which was passed to help ensure that patients fully understand arbitration agreements before signing them. Because Kaiser failed to comply with the requirements of the Act, the court determined that the agreement was unenforceable and that plaintiff was not required to submit her wrongful death claim to binding arbitration.  

*This case illustrates the importance of attention to detail when drafting agreements, particularly those containing arbitration provisions.*

**Washington Appeals Court Says Physician Has No Duty to Inform Third Party of Patient’s Condition**

In a situation in which a physician failed to revoke a signed sports authorization form after learning of the patient’s heart condition, the Washington Court of Appeals held that the physician had no duty to inform third parties about the patient’s condition. The court noted that state law permits a healthcare provider to disclose a patient’s health information to a third party on a reasonable belief that the disclosure will “avoid or minimize an imminent danger” to the patient’s health; however, it does not require the healthcare provider to do so. The court explained that the physician did have a duty to uphold physician-patient confidentiality.  

*This case illustrates the importance of maintaining physician-patient confidentiality, even when the result might be detrimental to the patient.*

**Connecticut Appeals Court Says Prior Lawsuit Involving Patient is Admissible Evidence in Malpractice Action**

The Appellate Court of Connecticut held that a prior lawsuit involving a patient is admissible when the patient opened the door to the issue of the prior lawsuit by
entering into evidence her medical record from the prior lawsuit. The court determined that the probative value of the evidence outweighed its prejudicial effect. 


*This case illustrates that physicians can present evidence of a patient’s litigious nature in a malpractice action if the patient opens the door to such evidence.*

**Indiana Appeals Court Says Medical Malpractice Act Does Not Create New Cause of Action for Wrongful Death of Fetus**

Parents brought a medical malpractice action against several healthcare providers, alleging negligence in the in utero death of their child Alicia. Defendants moved for a partial summary judgment, asking the trial court to determine, as a matter of law, that the Child Wrongful Death Act (Act) precluded the parents from bringing an action for the wrongful death of Alicia. Defendants also requested a judgment that the parents could not recover damages for any emotional distress caused by such death.

The Indiana Court of Appeals affirmed the trial court’s determination that the parents could not recover under the Act, but reversed on the issue of recovering damages for emotional distress. The appeals court explained that, although the Act does not create a new cause of action for the wrongful death of a fetus, this fact does not preclude a mother’s recovery of intangible damages resulting from the in utero death of her fetus. *Breece v. Lugo*, 800 N.E.2d 224 (Ind. Ct. App. 2003).

*Although wrongful death actions cannot be maintained against a physician for the death of a fetus, this case demonstrates that physicians can be held liable for any injuries to the mother resulting from this death.*

**X. MEDICAL RECORD ISSUES**

**Alabama High Court Says Psychotherapist-Patient Privilege Shields Records of Plaintiff Who Asserted Mental Anguish Claim**

Alabama tort defendants sought to discover the mental health records of plaintiff, who had brought claims for mental distress and anguish. The records were held by a third party mental health facility, which objected to the discovery by asserting the Alabama psychotherapist-patient privilege. Defendants argued that plaintiffs had waived the privilege by putting their mental health at issue in the tort case.

The Alabama Supreme Court held that the psychotherapist-patient privilege is statutory and covers the instant situation; however, the high court held that none of the statutory exceptions to the privilege permitted the release of mental health records when a party puts his mental health at issue. The supreme court also held that, because plaintiffs’ mental health-based claims were not “central” to their claims taken as a whole, denial of access to the mental health records did not jeopardize defendants’ state constitutional right to dispute claims against them in court.

This case demonstrates the proposition that testimonial psychotherapist-patient privilege in Alabama trumps a defendant’s need to examine a plaintiff’s mental health records in claims arising out of mental anguish.

Maryland Appeals Court Upholds Revocation of Physician’s License for Failure to Release Medical Records
The Court of Special Appeals of Maryland has ruled that the revocation of a physician’s medical license was an appropriate disciplinary sanction for the physician’s failure to cooperate with the Board of Physician Quality Assurance’s investigation. The physician refused to comply with the Board’s subpoena for patients’ medical records in connection with a review of the physician’s practice. The physician had argued that she was not under investigation by the Board for misconduct, the subpoena was overbroad, and her compliance with the subpoena would violate her patients’ privacy rights.


This case illustrates that physicians must cooperate in investigative matters conducted by medical boards. Although federal and state laws and regulations require physicians to protect the privacy of patients’ medical records, a physician must comply with a board’s request to access those records.

New Hampshire High Court Says State Grand Jury May Have Target’s Medical Records Only if Alternative Source of Same Information Unavailable
A county grand jury in New Hampshire issued a subpoena duces tecum to a hospital for the medical records of three defendants who had been admitted with injuries sustained in an automobile collision and were suspected of “felony aggravated driving while intoxicated.” Defendants moved to quash the subpoena based on the physician-patient privilege. The trial court agreed ordered the records disclosed.

The New Hampshire Supreme Court vacated the order. The supreme court ruled that the state may obtain privileged medical records only if (1) the information is not available from another source and (2) there is compelling justification for disclosure. The supreme court found compelling justification in the state’s need to investigate possible criminal activity, but it also found that the state had not shown that the information needed from defendants’ medical records was not available elsewhere. Consequently, the supreme court remanded the matter to the trial court to determine if facts existed to show that the state had alternative sources of the facts contained in defendants’ medical records. The supreme court gave guidance in the evaluation of the sufficiency of an alternative source for the information, including whether the “alternative” information would be admissible, whether the information could overcome a motion for directed verdict, and whether the state had made adequate efforts to determine if other sources for the information were available.

This case shows that medical records of accused defendants are available to New Hampshire law enforcement agency only if no other source for information is reasonably available.

U.S. Court in Maryland Says That, in Malpractice Action, HIPAA Prevents Unauthorized Revelation by Plaintiff’s Treating Physician of Plaintiff’s Medical Condition to Defendant’s Attorney

In a federal diversity malpractice action, plaintiff’s current physician improperly discussed plaintiff’s medical condition with the attorneys representing the defendant physician, who had previously treated plaintiff. Plaintiff argued that HIPAA’s privacy rules prevented her physician from engaging in an ex parte discussion of her medical condition with the attorney defending her former physician, whom she was suing for malpractice. Defendant argued that a Maryland statute made plaintiff’s medical information, including the subject of the ex parte conversation, available to defendant without plaintiff’s prior authorization.

The U.S. District Court for the District of Maryland held that HIPAA pre-empted the Maryland statute because it is “more stringent” in its protection of plaintiff’s medical information. Holding for plaintiff that the ex parte discussion was improper under HIPAA, the court reasoned that, “(i)f state law can force disclosure without court order, or the patient’s consent, it is not ‘more stringent’ than the HIPAA regulations.” The court further admonished that HIPAA requires that medical fact witnesses be treated with caution, as one would treat the “former employee of an adverse party [who has] been extensively exposed to confidential client information.” The court limited the application of its ruling to ex parte communications regarding a party’s medical information, withholding judgment as to HIPAA’s application to any other revelation of plaintiff’s medical information under the Maryland statute.


This case further illustrates how HIPAA and state laws collide. In this case, the court found that the HIPAA privacy rules pre-empt a state law that permits ex parte revelation of plaintiff’s medical information without plaintiff’s authorization.

XI. PAYMENT ISSUES

SSA ALJ Finds Statistical Sampling Invalid in Determining Overpayment

An administrative law judge (ALJ) has determined that the statistical sampling methodologies employed by the Medicare Carrier, National Heritage Insurance Company (NHIC), were invalid and violated due process of law. In concluding that the overpayment determination was invalid, the ALJ explained that NHIC’s statistical sampling methods were unfair and unreasonable because NHIC failed to document its statistical sampling methodology, failed to justify a sample size smaller than
recommended by CMS, failed to identify a random seed number, and failed to
generally comply with CMS directives.

_In re Gavigan_, Soc. Sec. Admin. Office of Hearings and Appeals No. 999-09-4291
(2003).

_The case is important because it shows that providers and physicians may
successfully challenge statistical sampling methodologies used by intermediaries or
carriers._

**Michigan Appeals Court Says Physician Was Not Liable for Improperly Certified
Fraudulent Claims Submitted by Employer**
The Michigan Court of Appeals held that a physician was not jointly and severally
liable for Medicaid overpayments for the fraudulent submission of claim forms by the
physician’s employer. The court concluded that the physician was relieved from
liability because the claim forms did not meet the statutory certification requirements.
Specifically, the claim forms did not contain the physician’s signature or the name of
the person signing the physician’s name. The appeals court noted that the physician
cannot be held jointly and severally liable because the claims should not have been
paid in the first instance as proper certification is an expressed condition to payment.

_Silverman v. Director of Mich. Dep’t. of Community Health_, No. 236473,  (Mich.

_This case offers protection to physicians who allow third parties to use their provider
numbers in submitting claims to Medicare/Medicaid._

**California Appeals Court Rules That Health Plan Was Not Required to Pay
Emergency Room Doctors**
The California Court of Appeals has ruled that health plans that contract with other
medical providers are not liable to physicians for non-payment. In this case, California
Emergency Physicians Medical Group (EPMG) provided emergency services for
patients who were insured by PacifiCare of California. PacifiCare chose Family Health
Network (FHN) as their medical provider to provide services to their enrollees. FHN
failed to pay EPMG for the medical services it provided because it filed for bankruptcy
and went out of business.

_California Emergency Physicians Med. Group v. PacifiCare_, 4 Cal. Rptr.3d 583

_This case is important because it confirms that health plans often will have no liability
to physicians who provide services in a provider network absence a direct contractual
arrangement between the physicians and the health plans. This case illustrates how
physicians can often have no recourse for getting paid for their services in a situation
where the provider network with which they contract is not financially viable._
XII. PROFESSIONAL RIGHTS

California Appeals Court Says That Terminating Relationships with Patients Who Sue For Malpractice Does Not Violate Anti-Discrimination and Unfair Competition Laws

Patricia and John Thompson brought an action against Scripps Clinic for terminating care of Mrs. Thompson after she filed a medical malpractice action against Clinic physicians. Scripps’ policy is to terminate relationships with all patients and their families who file lawsuits against a Clinic physician. The Thompsons sued Scripps, alleging, among other things, intentional interference with contract, negligent infliction of emotional distress, breach of fiduciary duty, violation of the Unruh and Cartwright Acts, and unfair competition. The trial court denied Scripps’ motion for summary judgment. The California Court of Appeals, vacating the denial of summary judgment for four of the six causes of actions, held that the policy did not violate the Unruh Act, the Cartwright Act, unfair competition, or breach of public policy. First, the appeals court explained that the policy did not violate the Unruh Act because Scripps’ policy applies to all patients who sue the group, regardless of their personal characteristics. Second, the court said that the policy did not violate the Cartwright Act because the evidence failed to show how the policy resulted in a restraint of trade. Finally, the appeals court determined that the policy did not violate unfair competition laws or public policy because the policy did not prevent a patient from suing for malpractice. 


This case shows that a physician or hospital can lawfully withdraw from treating a patient and demonstrates the contractual nature of the physician-patient relationship.

New York High Court Says No Duty of Care Is Owed to Non-Patient

The New York Court of Appeals held that no duty of care is owed to non-patients in cases in which a physician fails to advise a non-patient that treatment is needed and there is no special relationship between the physician and non-patient. The case arose when two physicians told a non-patient that she did not need treatment after being exposed to their patient, who had a highly contagious form of meningitis; the non-patient later contracted the same form of meningitis. The appeals court noted that courts are reluctant to expand a physician’s duty of care to non-patients.


This case demonstrates the courts reluctance in requiring the same duty of care to patients and to non-patients.

Connecticut Appeals Court Says That Qualified Immunity Trumps Common Law Absolute Immunity

Defendants, licensed physicians in Connecticut, sought summary judgment against a claim of defamation on the basis of state-law qualified immunity and common-law absolute immunity. Defendants appealed after the motion was denied. The case arose when defendants submitted affidavits expressing concern about plaintiff, which led to
the suspension of plaintiff’s license. Plaintiff sued, and defendants claimed immunity. The Connecticut Court of Appeals ruled that Connecticut’s qualified immunity statutes abrogated common law absolute immunity. The appeals court examined the statutory language of the state qualified immunity and concluded that the plain language of the statute provided limited immunity and when there is an overlap between state qualified immunity and common law, the state’s immunity statute is used. 


*This case illustrates that the generous protection afforded to physicians under common law may be trumped by a lesser degree of protection under state law.*

**California Appeals Court Rules That Failure to Complete Substance Abuse Diversion Program Was Not Enough to Revoke Physician’s License**

The California Court of Appeals has held that a physician’s mere failure to successfully complete a substance abuse diversion program was not a basis for discipline. The court explained that, in order to justify an imposition of discipline, there must be some nexus between an act or omission and the professional’s fitness or competence to practice. Specifically, the appeals court concluded that, to satisfy the due process considerations that attach in disciplinary actions against a professional license, there must be some reasonable indication that a failure to complete diversion program successfully constitutes unprofessional conduct before it may be applied to impose discipline solely on that ground.

**Medical Board v. Superior Court**, 4 Cal. Rptr.3d 403 (Cal. Ct. App. 2003).

*This case shows that due process must be given to physicians threatened with the possibility of losing their medical license. It indicates the importance of medical review boards to prove that an omission or failure to complete a requirement affects the fitness of the physician to practice medicine.*

**Ninth Circuit Finds Psychiatrist’s Testimony About Patient’s Threats Is Not Proper**

In a situation involving a psychiatrist’s disclosure of a patient’s threats to law enforcement and the subsequent testimony by the psychiatrist regarding those threats, the Ninth Circuit, en banc, held that the admission of the psychiatrist’s testimony about the patient’s threats was erroneous because the patient’s statements were for the purpose of obtaining treatment. The appeals court indicated that “confidentiality” refers to state privacy laws for the psychotherapist-patient relationship, and “privilege” refers to the right of a patient to prevent a psychotherapist from testifying about communications. The appeals court concluded that the patient threats constituted a crime, but the state law on confidentiality and the federal testimonial privilege applied.

**United States v. Chase**, 340 F.3d 978 (9th Cir. 2003).

*This case illustrates that the “dangerous threat” exception to the psychotherapist-patient confidentiality requirements does not extend to testimony.*
Texas Supreme Court Finds No Battery Occurred When Medical Staff Acted to Save Life of Infant Without Parental Consent

Plaintiffs informed physicians at Woman’s Hospital of Texas that they did not want any heroic measures performed on their infant after birth. The premature infant was born alive and was immediately placed on ventilation equipment. The infant suffered a brain hemorrhage that resulted in severe physical and mental impairment a few days following birth. Plaintiffs filed suit, alleging battery and negligence. The Texas Supreme Court held that no battery had taken place and affirmed the appeals court’s decision that parents of children with non-terminal impairments do not have the right to withhold medical treatment. The appeals court acknowledged that the general rule regarding consent is that a “physician who provides treatment without consent commits battery,” but explained that an exception exists for emergent circumstances in which there is no time to consult the parents. 

**Miller v. HCA, Inc.,** 118 S.W.3d 758 (Tex. 2003).

*The case illustrates the interplay between consent and a claim for battery in emergency situations.*

New Jersey Supreme Courts Finds Physician’s Advertisements Insulated from Consumer Fraud Claim

Joseph Macedo and Rosemary Lesky sued Dr. Joseph Dello Russo, the corporate entities he created to perform laser surgery, and Dr. Williams T. Kellogg (collectively “defendants”), alleging that defendants violated the Consumer Fraud Act (CFA) when they allowed Kellogg, who was not fully licensed, to treat plaintiffs. The trial court granted defendants’ motion to dismiss because the claim was outside the purview of the CFA. On leave to appeal, the Appellate Division reversed.

Disagreeing with the appeals court, the New Jersey Supreme Court held that physician’s advertisements relating to the provision of professional services are insulated from claims under the CFA. The court explained that, because the legislature has failed to amend the CFA in response to judicial determination that the CFA does not apply to professionals that are acting within their professional capacity, courts must conclude that the legislature has approved of the judicial treatment of professionals in regards to the CFA. The supreme court noted that, if defendants had acted outside their professional capacity, they would be subject to the CFA.


*This case provides further protection to physicians in cases involving consumer fraud.*

Maryland Appeals Court Upholds Revocation of Physician’s License for Failure to Release Medical Records

The Court of Special Appeals of Maryland has ruled that the revocation of a physician’s medical license was an appropriate disciplinary sanction for the physician’s failure to cooperate with the Board of Physician Quality Assurance’s investigation. The physician refused to comply with the Board’s subpoena for patients’ medical records in connection with a review of the physician’s practice. The physician
had argued that she was not under investigation by the Board for misconduct, the subpoena was overbroad, and her compliance with the subpoena would violate her patients’ privacy rights.


*This case illustrates that physicians must cooperate in investigative matters conducted by medical boards. Although federal and state laws and regulations require physicians to protect the privacy of patients’ medical records, a physician must comply with a board’s request to access those records.*

**Ninth Circuit Holds That Physicians Cannot Advertise “Board Certified” Unless Certifying Agency Meets Statutory Standards**

The Ninth Circuit has found valid a California statute that prohibits physicians from representing they are “board certified” unless the certifying organization (1) is a member board of the American Board of Medical Specialties (ABMS), (2) has requirements equivalent to those of the ABMS, or (3) has a postgraduate training program approved by the Accreditation Council for Graduate Medical Education that provides complete training in the designated specialty. Cal. Bus. & Prof. Code §651(h)(5)(B). The Ninth Circuit explained that the physicians were only prohibited from using the term “board certified” and could still advertise their membership in the non-certified organization.

**American Acad. of Pain Management v. Joseph**, 353 F.3d 1099 (9th Cir. 2004).

*This case illustrates the balance between free speech and truthful advertising. Untrue advertisements touting a healthcare provider’s credentials or quality are not protected commercial free speech under the First Amendment; the truth of advertisement of physician’s “board certification” will be determined by compliance with California statute.*

**Kentucky Appeals Court Clarifies “Under Investigation” for Purpose of Reporting Resigning Staff Member to NPDB**

A medical executive committee (MEC) obtained an independent review of a staff member cardiologist’s prior cases after doubt was raised about the cardiologist’s quality of care. Shortly before the MEC met to review the independent findings, the cardiologist resigned. The hospital reported the resignation to the National Practitioner Data Bank (NPDB) as having occurred while a quality-related investigation was pending. The cardiologist sued the hospital, seeking a declaration that he had not been “under investigation” for purposes of NPDB reporting at the time he resigned. Plaintiff alleged that an investigation could not have been pending because the hospital had failed to follow its bylaws for the commencement of an investigation.

Finding present all of the elements of “an investigation,” and discounting the significance of the hospital’s technical deviation from its own bylaws, the Kentucky Court of Appeals held that the hospital had properly reported the cardiologist’s resignation as occurring while he was “under investigation.” The appeals court
explained that, “even if the [MEC] failed to give [the cardiologist] formal notice of an investigation as contemplated by the bylaws . . . the medical staff’s and the hospital’s scrutiny of his practice clearly amounted to an investigation for purposes of the [Health Care Quality Improvement Act].” Specifically, the appeals court found that the earmarks of an investigation as set forth in Department of Health and Human Services guidelines were present: (1) the investigation was carried out by the hospital and not merely by individuals, (2) the scrutiny focused on a physician whose professional competence was questioned, and (3) the scrutiny was undertaken as a precursor to a professional review action.


This case illustrates that technical failure of hospital to follow its own rules regarding the commencement of an investigation of a staff member does not defeat the conclusion that an investigation was actually begun if the purported investigation satisfies the elements set forth in DHHS guidelines.

U.S. Court in Missouri Refuses Substantive Review of Hospital Medical Quality Committee’s Findings When Action Was Taken in Belief That It Furthered Quality Healthcare

Hospital revoked physician’s privileges for medical quality reasons. Physician sued, claiming that she was the victim of the peer reviewers’ defamation, intentional interference with contract, breach of contract, antitrust violation, unfair trade practices, and violation of the Health Care Quality Improvement Act (HCQIA). The U.S. District Court for the Western District of Missouri held that the peer review process had comported with the due process requirements of the HCQIA and that, therefore, the peer reviewers were immune from damages. Relying on Sugarbaker v. SSM Health Care, 190 F.3d 905 (8th Cir. 1999), the court found the defendants: (1) had acted in the reasonable belief that their actions furthered quality healthcare, (2) had made a reasonable effort to gather the relevant facts regarding the physician, and (3) had given plaintiff adequate notice and hearing procedures, and that plaintiff need not have been allowed to attend or participate in all deliberations of the peer review committee. The court also found that the final action of the peer review process was reasonable and warranted under the circumstances after compliance with mandated procedures. Importantly, the court emphasized that it was immaterial that the peer reviewers may have reached an incorrect conclusion on the medical issues before them, so long as they had operated under the proper motivation—the furtherance of quality healthcare.


This case involves HCQIA protection and shows that, under the HCQIA, peer reviewers gain insulation from damages if they objectively comply with HCQIA’s procedural obligations, regardless of whether their factual determinations are correct.
Idaho High Court Says That Medical Staff Bylaws Are Not Contract Between Physician and Hospital

Hospital denied plaintiff physician’s application for staff membership based on evidence of physician’s earlier disruptive behavior at other institutions. Plaintiff sued for injunctive relief that hospital grant him privileges and a declaration that the credentialing process was void because it denied him due process. The trial court dismissed plaintiff’s claims, finding that the hospital had not acted in bad faith. In doing so, however, the trial court characterized the hospital medical staff bylaws as a contract between the physician and the hospital entered the moment the physician applied for membership and privileges. On appeal, the Idaho Supreme Court held that the bylaws were not contractual, but rather provided the procedures that the hospital would follow in processing peer review matters. The high court noted that Idaho statutes require a hospital to institute written fair procedures for the handling of peer review matters; it followed, therefore, that the hospital bylaws were adopted pursuant to such statutes. Accordingly, the high court held, “the appropriate standard of judicial review . . . is limited to determining whether the procedures adopted by the Hospital [bylaws] afforded applicant due process, whether the procedures included the [Idaho statutory] requirements, and whether the Hospital substantially followed its procedures.”


This case illustrates that, under Idaho law, medical staff bylaws constitute procedural rules for peer review actions, but do not constitute a contract between hospital and physician.

XIII. TAX ISSUES

Tax Court Grants Employment Tax Relief for Medical Services Provider

Medical Emergency Care Associates (MECA) provided emergency medical services to hospitals. MECA contracted with physicians to staff hospital emergency rooms and treated those physicians as independent contractors. In 1996, MECA failed to timely file required Forms 1096 and 1099. Additionally, MECA delinquently filed those forms on a basis consistent with its treatment of the physicians as independent contractors. After an investigation, the Internal Revenue Service determined that the physicians were actually employees of MECA and that MECA was not entitled to relief because it did not meet the filing requirement under § 530 of the Internal Revenue Code, which operates to provide relief under certain circumstances from employment tax liability notwithstanding the actual relationship between the taxpayer and the individual performing the services. The U.S. Tax Court held that MECA was entitled to relief from employment tax liability under § 530 because MECA (1) did not treat the physicians as employees for any period, (2) filed all federal tax returns on a basis consistent with MECA’s treatment of the physicians as independent contractors, and (3) had a reasonable basis for not treating the physicians as employees. The Tax Court also concluded that MECA’s untimely filing of information returns did not preclude it from qualifying for such relief.

This case shows that the Internal Revenue Service is becoming more vigilant in looking at the employee-independent contractor distinction, and is more willing to recharacterize independent contractors as employees.
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I. CASE SUMMARIES

DC Circuit Says CMS Not Obligated to Correct Error in Hospital’s Supporting Documentation
The Centers for Medicare and Medicaid Services (CMS) denied St. Luke’s Hospital’s (St. Luke’s) request for an exception to the prevailing end-stage renal disease composite rate because the request contained an error in the supporting documentation. In denying the request, CMS said that St. Luke’s error prevented the hospital from presenting “convincing objective evidence” as required by 42 C.F.R. § 413.170(g). St. Luke’s argued that the error did not provide a basis for denial because it did not affect CMS’ analysis, and, alternatively, even if the error was significant, the correct information was present elsewhere in the request.

The D.C. Circuit decided in favor of the Secretary of Health and Human Services, stating that its decision turned on what CMS could reasonably be expected to do in such a situation. The appeals court concluded that CMS was not obligated to correct the hospital’s error. In the case of an exception request, CMS regulations place the burden of proof on the provider to convince the agency that it deserves an exception. Additionally, St. Luke’s submitted its exception request on the last day of its 180-day jurisdictional window, which left CMS no time to request additional data. Had St. Luke’s submitted the exception request earlier, CMS could have requested data that would have corrected the error. The appeals court wrote that “St. Luke’s essentially gambled that its exception request would be error-free.” Therefore, there was nothing arbitrary and capricious in the Secretary’s decision.


A federal appeals court found that CMS was reasonable in declining to correct a hospital’s error in supporting documentation.

Fifth Circuit Finds No Appealable Initial Determination in CMS’ Mistaken Categorization of Mental Health Carriers
Three community mental health centers (CMHCs), in their application to participate in the Medicare program, sought provider-based status. However, CMS mistakenly categorized the CMHCs as free-standing. Upon correction of the error, CMS refused to apply the change retroactively, and the CMHCs appealed to the Departmental Appeals Board (DAB), which dismissed the appeal for lack of jurisdiction, stating that there was no appealable initial determination. A federal district court affirmed the DAB’s decision, and the CMHCs appealed.

The Fifth Circuit affirmed. On appeal, the CMHCs argued that (1) CMS’ classification of the CMHCs as free-standing constituted an initial determination, (b) the DAB violated their procedural due process rights by dismissing the case without
considering an issue critical to the holding, and (c) the DAB’s decision was arbitrary and capricious because the DAB “had previously exerted jurisdiction over two reimbursement classification disputes.” In an unpublished opinion, the appeals court agreed that the DAB did not have jurisdiction because, at the time of the CMHCs’ claims, a classification of free-standing was not considered an initial determination. Community Mental Health Ctr. v. Social Security Admin., 86 Fed.Appx. 777 (5th Cir. 2004).

The Fifth Circuit agreed that the Departmental Appeals Board lacked jurisdiction at a time when the classification of “free-standing” was not considered an initial determination.

Tenth Circuit Upholds PRRB Dismissal of Appeal for Missed Deadline

The Provider Reimbursement Review Board (PRRB) dismissed High Country Home Health’s (High Country) appeal of a revised Notice of Program Reimbursement (NPR) for fiscal year 1994 because of a missed position paper deadline. High Country sought judicial review in federal district court, challenging the PRRB’s dismissal of the appeal and the revised NPR. The district court affirmed, and High Country appealed.

The Tenth Circuit affirmed. The appeals court held that the PRRB’s decision to dismiss the appeal was not arbitrary and capricious, emphasizing that the PRRB has Congressional authority to make procedural rules necessary for effectuating the appeals process, such as the rule allowing the PRRB to dismiss an appeal if a provider fails to submit a final position paper by the due date. According to the appeals court, “[t]he Board could have heard all of High Country’s complaints about the Intermediary’s procedural and substantive mistakes [in regard to the revised NPR] if they had been timely presented, and when they were not, the Board was under no obligation to consider the merits before dismissing the claims on procedural grounds.” High Country Home Health, Inc. v. Thompson, 359 F.3d 1302 (10th Cir. 2004).

A federal appeals court upheld the PRRB’s right to create and enforce procedural rules for its appeals process and found the PRRB was reasonable in its dismissal of an untimely appeal.

First Circuit Vacates Preliminary Injunction Barring Massachusetts from Implementing Emergency Pharmacy Rate Reduction Regulation

The Long Term Care Pharmacy Alliance (LTCPA) is an alliance of closed pharmacies that provide prescription drugs to residents of nursing homes. The Commonwealth of Massachusetts (Commonwealth) passed an emergency regulation that reduced the rates it pays to pharmacies for prescription drugs furnished to Medicaid patients. The LTCPA challenged the rate reduction on the grounds that the Commonwealth was required by the Social Security Act (SSA) to provide a hearing on the rate reduction and use a public process to set payment rates for nursing facility services. A federal district court enjoined the Commonwealth from implementing the regulation, and the Commonwealth appealed.
The First Circuit vacated the preliminary injunction. On appeal, the LTCPA asserted that the SSA requires that rates for services be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” In response to the first prong of the LTCPA’s argument, the appeals court defined “nursing facility services” to be services provided by the nursing facility. The closed pharmacies were providing services to the nursing facility, and were therefore analogous to suppliers, not providers. According to the appeals court, the LTCPA’s argument was thus inapplicable to the closed pharmacies reimbursement rates in question. Regarding the second prong of the LTCPA’s argument, the court held that the applicable section of the SSA did not create a private right of action.

**Long Term Care Pharmacy Alliance v. Ferguson**, No. 03-1895, 2004 WL 513790 (1st Cir. March 17, 2004).

*The First Circuit allows Massachusetts to implement emergency pharmacy rate reduction regulation.*

**U.S. Court in District of Columbia Upholds DHHS Secretary’s Refusal to Permit New Provider Exception from RCLs**

St. Elizabeth’s Medical Center of Boston (St. Elizabeth’s) applied for a new provider exemption in January of 1997 after opening a skilled nursing facility (SNF). The Commonwealth of Massachusetts would only approve the construction of a new SNF if a determination of need existed (DON), and, at the time, the only way to obtain a DON was through the acquisition of the operating rights of an existing long term care facility. In order to receive a DON, St. Elizabeth’s acquired bed-operating rights from Friel Nursing Home (Friel) in February 1996. In July 1996, the Massachusetts legislature passed a new statute permitting hospitals to open a new SNF without acquiring a DON through the purchase of already-existing operating rights. In October, the Massachusetts Department of Public Health granted St. Elizabeth’s a DON under the new statute. CMS denied St. Elizabeth’s application for a new provider exemption on the basis that (1) St. Elizabeth’s SNF “was established due the purchase and relocation of . . . beds from [Friel],” (2) Friel was “an equivalent provider of . . . services,” (3) St. Elizabeth’s had operated as the equivalent of a SNF, and (4) the relocation provision of PRM § 2604.1 did not apply because no substantial difference in inpatient population existed.

The U.S. District Court for the District of Columbia ruled in favor of the DHHS Secretary in his decision not to permit a new provider exception from routine cost limits under 42 C.F.R. § 413.30(e). Among its arguments on appeal to the federal court, St. Elizabeth’s asserted that Friel was not the previous “provider of inpatient services” and that the term provider unambiguously referred to a hospital, home health agency, or a SNF. In response, the Secretary stated that the term “provider” is ambiguous, and that the court should defer to the Secretary’s interpretation. The court followed the Seventh, Ninth, and First Circuits in stating that § 413.30 is ambiguous and gave deference to the agency’s interpretation. Overall, the court found that the
Secretary’s decision was not arbitrary, capricious, or unsupported by substantial evidence, but rather reasonable and rationally connected to the facts of the case. *St. Elizabeth’s Med. Ctr. v. Thompson*, No. 03-0153, 2004 WL 504150 (D.D.C. March 11, 2004).

*A federal district court found the DHHS Secretary reasonably interpreted 42 C.F.R. § 413.30(e) as not permitting a new provider exception from routine cost limits.*

**U.S. Court in District of Columbia Finds No Public Interest in Maintaining Legally Infirm Payment Determinations**

Invoking the court’s mandamus jurisdiction, plaintiff hospitals contended that HCFA Ruling 97-2 triggered a mandatory duty on CMS’ part to reopen and revise earlier Medicare payment determinations that were issued in 1994-97.

The U.S. District Court for the District of Columbia, extending the rationale of the D.C. Circuit’s earlier decision in *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001), granted plaintiffs’ motion for summary judgment and issued a writ of mandamus compelling the agency to reopen and revise the earlier payment determinations. In a fifteen-page memorandum opinion, the district court concluded that, under the rule of law, which serves as a “founding principle of this Republic,” “[t]here is no public interest in maintaining legally infirm [payment determinations].” *Baystate Med. Ctr. v. Thompson*, No. 03-0090, 2004 WL 596088 (D.D.C. March 26, 2004).

*A federal district court compelled CMS to reopen and revise payment determinations after finding no public interest in maintaining determinations that were legally infirm.*

**Tenth Circuit Says DHHS Had No Duty to Reopen and Recalculate Hospital Cost Reports**

The Tenth Circuit revisited a decision it vacated on August 22, 2003. Reversing and remanding the lower court’s decisions, the judgment remained the same as the Court’s earlier, vacated opinion in holding that hospitals were not entitled to mandamus jurisdiction because they had failed to show that the Secretary had a non-discretionary duty under the regulations governing mandatory or discretionary reopenings. Therefore, the appeals court held, Ruling 97-2 did not constitute notification under the mandatory reopening provision, and HHS had no duty to reopen and recalculate the cost reports of Bartlett Memorial Medical Center and other Oklahoma hospitals. The previous opinion was withdrawn as it had been issued unanimously when in fact one of the judges had dissented in part, finding that a clear non-discretionary duty to reopen existed. *Bartlett Mem’l Med. Ctr. v. Thompson*, 347 F.3d 828 (10th Cir. 2003).

*The Tenth Circuit declined to follow the D.C. Circuit and held that DHHS had no duty to reopen and recalculate hospital cost reports because the relevant HCFA rule did not constitute notification under the mandatory reopening provision.*
U.S. Court in Minnesota Says Medicaid DSH Program Memorandum Did Not Violate Hospital’s Equal Protection Right

Plaintiff hospital was unable to convince a federal court that, among other things, its right to equal protection had been violated by Program Memorandum (PM) A-99-62, which clarified the formula for Medicaid DSH reimbursement found in 42 U.S.C § 1395ww(d)(5)(F)(vi). The PM had been issued in response to confusion arising from whether or not non-Medicaid general assistance patient days were included in the total number of patient days used in the DSH Medicaid Proxy. Plaintiff took issue with an aspect of the PM relevant to cost reporting periods beginning before January 2000. This provision allowed hospitals that had not received overpayments but had filed an appeal with the PRRB prior to October 15, 1999, to receive payment for general assistance days. United had timely filed appeals with the PRRB, but had not included general assistance days as part of the original appeal. In 2000 and prior to the PRRB hearing, United added the issue of general assistance days. All other issues were resolved administratively, but the PRRB denied United’s claim regarding the general assistance days, as it had not appealed the days at issue prior to the October 14, 1999, deadline. In its judicial challenge, United argued that (1) it met the requirements for relief, (2) the PM illegally limited United’s right to appeal, (3) the Secretary’s application of the DSH regulation was arbitrary and capricious, and (4) the Secretary’s application of the DSH regulation violated its right to equal protection.

In all instances, the U.S. District Court for the District of Minnesota ruled against United, stating that the October 15, 1999, “deadline separates those hospitals that were legitimately confused from those hospitals that sought to benefit from the confusion of others.”


This case demonstrates the court’s willingness to uphold an appeals deadline, noting that deadline was meant to protect hospitals that were legitimately confused by Medicaid payment rules.

U.S. Court in Illinois Pays Deference to DHHS Secretary’s Determination of Outlier Payments Because Relevant Statute Was Ambiguous

In the years in question, the Secretary of Health and Human Services set the outlier threshold at 5.1%, while the actual outlier payments fell short of the threshold. Plaintiff hospital argued that the statutory language regarding outlier payments states that the actual reimbursement for outlier payments must fall within the 5% to 6% range based on the diagnosis-related group (DRG) prospective payment system (PPS) rates for the year and that the shortages should be retroactively reimbursed. The Secretary argued that CMS must “prospectively establish the fixed thresholds . . . at levels likely to result in outlier payments between 5-6 percent of the project DRG prospective payments for that year.”

The U.S. District Court for the Northern District of Illinois upheld the Secretary’s determination of outlier payments for 1991 to 1994 and 1996. In its decision, the court
found the wording of the statute was ambiguous, and therefore, the Secretary’s interpretation was due deference. Furthermore, the court held that CMS’s interpretation of the statute was correct because (1) CMS had consistently interpreted the statute since the inception of the inpatient hospital PPS, (2) the interpretation was consistent with the purposes of PPS, and (3) Congress had amended the statute in question without any changes to CMS’s interpretation of the issue.


*The court emphasized that, because the relevant statute was ambiguous, deference to the Secretary’s interpretation was due.*

**Fifth Circuit Says CMS Administrator Was Arbitrary and Capricious in Ruling that RHCs Could Not Be Considered for DSH Calculations**

Louisiana sought guidance from the Department of Health and Human Services on how to include the costs of hospital-based rural health clinics (RHCs) in the DSH payment adjustment. The Secretary responded by stating “if Louisiana were to create a process to license (sic) or ‘formally approve’ hospital-based RHCs as hospital outpatient departments, then the clinics’ uncompensated care costs associated with providing hospital outpatient services could be included in the DSH calculation for their affiliated hospitals.” In response, the Louisiana legislature amended the corresponding state statute, and the State submitted an amendment to their State plan providing for the consideration of uncompensated care costs of RHCs licensed as part of a small rural hospital in the DSH calculation. CMS rejected the amendment on the basis that RHCs do not furnish hospital services, and a CMS Administrator upheld CMS’s rejection of the State plan amendment.

The Fifth Circuit found the CMS Administrator’s decision that RHCs could not be taken into account for DSH calculations was arbitrary and capricious. The appeals court held that services provided by hospital-based RHCs fall within the definition of hospital services, reimbursing RHCs for such services is in line with Congressional intent with regard to DSH payment adjustments, and CMS’s own regulations recognize that hospital-based RHCs are integral to the functions of parent hospitals.

*Louisiana Dep’t of Health and Hosps. v. Centers for Medicare and Medicaid Servs.*, 346 F.3d 571 (5th Cir. 2003).

*The Fifth Circuit found arbitrary and capricious a CMS Administrator decision rejecting a State plan amendment providing for the consideration of uncompensated care costs of RHCs licensed as part of a small rural hospital in the DSH calculation.*

**U.S. Court in Minnesota Says DHHS Secretary Was Not Arbitrary and Capricious in Declining to Apply 1985 Amendment to IME Calculations for Hospitals That Elected Waiver Prior to Amendment’s Effective Dates**

Plaintiff hospitals sought additional indirect medical education (IME) reimbursement for cost reporting years between January 1, 1983, and December 31, 1985. The hospitals had elected a 602(k) waiver, which temporarily exempted hospitals that had
arrangements with other institutions to provide ancillary services from the administrative burden of the re-bundling provision of the prospective payment system. HCFA in turn calculated the hospitals' IME reimbursement differently, based only on a portion of the DRG that the hospital paid directly and not including the portion paid by the institution providing the ancillary services. In 1985, Congress passed an amendment stating that hospitals electing a 602(k) waiver be paid based on the full DRG amount with an effective date of cost reporting periods beginning on or after January 1, 1986.

The U.S. District Court for the District of Minnesota found that the Secretary of Health and Human Services' decision not to apply the 1985 amendment to the calculation of IME for hospitals that had elected a 602(k) waiver prior to the effective dates listed in the amendment was not arbitrary and capricious. The court held that the text of the statute was clear, despite the fact that the legislative history seemed to contradict the actual IME amendment text.  

*The court upheld the Secretary’s conclusion that a 1985 amendment to IME calculations did not apply to hospitals that had elected a 602(k) waiver prior to the effective dates of the amendment.*

**Second Circuit Says Provider Failed to Support Claim for Mandamus Jurisdiction**  
Caremark sought mandamus jurisdiction to compel Noridian, its carrier, to reopen an overpayment determination. Noridian sent Caremark a written notice of overpayment on March 23, 2000, but Caremark did not submit a request for review of the determination until the six-month time period for doing so had lapsed. Noridian dismissed the belated request, and several subsequent written requests, as untimely. Caremark argued that Noridian had a non-discretionary duty to reopen the determination and that all administrative remedies had been exhausted because the denial of the request to reopen was not appealable.

The Second Circuit affirmed the district court’s decision not to exercise mandamus jurisdiction in favor of Caremark. The appeals court held that Caremark had failed to support mandamus jurisdiction because (1) Caremark failed to demonstrate that Noridian had a non-discretionary duty to reopen the overpayment determination, and (2) Caremark had failed to exhaust its administrative remedies by failing to file a timely request for reopening.  

*The appeals court agreed that a healthcare provider failed to support a claim for mandamus jurisdiction by failing to demonstrate that its carrier had a nondiscretionary duty to reopen a payment determination.*
II. JCAHO UPDATE

National Patient Safety Goals for 2005
On February 6, 2004, the Sentinel Event Alert Advisory Group (Group) met to begin identifying potential National Patient Safety Goals (NPSGs) for 2005. The Group supported phasing in some goals by allowing for less than 100% compliance; developing program-specific NPSGs; disseminating potential new goals for field review; adding a patient family advocate to the twenty-three-member Group; and providing supportive information with the goals, including rationale and evidence-based data. The Group will meet in May 2004 to discuss the results of the March field review of the 2005 NPSGs and make recommendations that will go to the Board of Commissioners for review and approval at the Board’s July 2004 meeting.

At its February meeting, the Group also clarified issues surrounding three of the requirements of the 2004 NPSGs, as follows:
For Goal 2b, use of “trailing zero” will continue to be prohibited for medication dosages and dosage notations but may be used for laboratory test results and equipment sizes.
For Goal 3b, the “Rule of Six” should not be used for pediatric or neonatal care. The Group suggested a six to twelve month timeframe for implementation.
For Goal 5a, the requirement for intrinsic free-flow protection on all general purpose and PCA intravenous infusion pumps shall be maintained. Any organization that is cited for non-compliance with Goal 5 for using pump/administration set configurations for which intrinsic free-flow protection is not available will be handled on a case-by-case basis to ensure that the organization is not inappropriately penalized. New purchases of unprotected equipment will not be permitted under this goal.

JCAHO to Develop LVRS, LVAD Certification Programs
The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is developing two additional Disease-Specific Care (DSC) certification programs for Lung Volume Reduction Surgery (LVRS) and Left Ventricular Assist Devices (LVAD).

During LVRS, the most severely damaged portions of the lung are removed to provide muscular relief and expand respiratory capacity for certain patients suffering from emphysema. Currently, CMS provides payment coverage for LVRS for individuals with non-high-risk emphysema performed by organizations that meet the National Emphysema Treatment Trial criteria. In the future, CMS’ coverage decisions will be based on whether the organization meets national accreditation standards.

LVADs provide permanent mechanical cardiac support for those with chronic end-stage heart failure who meet certain conditions. Organizations wishing to pursue either LVRS or LVAD certification will be required to meet both the basic standards in the DSC Manual and the requirements in the LVRS- or LVAD-specific addendums.
JCAHO hopes to complete the LVRS standards by May 1, 2004, and launch the LVRS certification program by mid-2004. JCAHO will develop the LVAD standards following the completion of the LVRS certification program.

**JCAHO Receives Grant for Cultural and Linguistic Project**

JCAHO received a grant from the California Endowment to fund a project that will determine the capabilities of hospitals around the country to address issues of language and culture and result in recommended practices for hospitals to make their services more culturally and linguistically appropriate. The project began in January 2004 and involves three phases over two-and-a-half years.

**Ambulatory Care, Laboratory, Long Term Care and Disease-Specific Care NPSGs**

In January 2004, the Executive Committee of the Board of Commissioners approved ambulatory care, laboratory, long term care, and disease-specific care NPSGs for 2004. This completes the first phase of JCAHO's planned effort to make goals and requirements more relevant to the non-hospital accreditation and certification programs. Program-specific NPSGs can be accessed at the JCAHO Web site. The second phase of this effort to develop program-specific goals and requirements will include identifying new program-specific evidence—or experienced-based goals and requirements. The new goals and requirements have a proposed implementation date of January 1, 2005, pending approval by JCAHO's Board of Commissioners.

**Communicating Survey Results**

Since JCAHO’s new accreditation process stresses continuous standards compliance and organizational improvement, but does not include a final “score,” organizations have sought guidance from JCAHO as to the best way to communicate survey results to their governing bodies, staff, and the public. JCAHO suggests the following ways to communicate the success of an on-site survey: (1) stress that the organization has undergone a thorough on-site review and is committed to meeting rigorous national standards—continuously, (2) detail full compliance with areas such as challenging standards or the level of compliance with the nearly 250 hospital standards, (3) emphasize compliance with NPSGs, (4) share ORYX data or national improvement goals, (5) emphasize the improvements found during an on-site survey on issues identified during a periodic performance review, (6) share information about improvement efforts, and (7) discuss specific examples where staff involvement was vital to the on-site survey because of the focus on patient care.

**JCAHO Announces 2004 National Patient Safety Goals**

On July 21, 2003, JCAHO approved the NPSGs for 2004. The NPSGs include the 2003 goals with the addition of a new NPSG that focuses on reducing the risk of healthcare-acquired infections. JCAHO expanded the 2003 requirement to “read back” verbal and telephone orders in order to confirm accuracy to include the read-back of critical test results that are communicated verbally. The new NPSG for 2004 focuses on reducing the risk of healthcare-acquired infections. To meet the new NPSG, healthcare organizations must comply with current hand-hygiene guidelines issued by
the Centers for Disease Control and Prevention and manage all identified cases of unanticipated death or major permanent loss of function associated with a healthcare-acquired infection as sentinel events. Beginning January 1, 2004, JCAHO-accredited healthcare organizations will be evaluated for compliance under the applicable 2004 NPSGs. The 2004 NPSGs may be found at http://www.jcaho.org/news+room/news+release+archives/npsg_04.htm.

Universal Protocol Established for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery
JCAHO’s Board of Commissioners approved a universal protocol for preventing wrong site, wrong procedure, and wrong person surgery. Beginning July 1, 2004, JCAHO-accredited organizations that provide surgical services must comply with the new universal protocol.

By expanding and integrating a series of existing requirements under the 2003 and 2004 NPSGs, the universal protocol strives to set a goal of zero-tolerance for surgeries on the wrong site or the wrong person, or the performance of the wrong surgical procedure. The Universal Protocol will apply to all operative and other invasive procedures and will include the following principal components: (1) the pre-operative verification process, (2) marking of the operative site, (3) taking a “time out” immediately before starting the procedure, and (4) adapting the requirements to non-operating room settings, including bedside procedures.

Additional Performance Data Required for Hospitals in 2004
Beginning in January 2004, JCAHO requires accredited hospitals to collect and report performance measure data on an additional set of core performance measures.

The new requirement increases the scope of hospital collection and reporting of performance measure data from two to three sets of core measures. Hospitals can currently choose from four core measure sets that address acute myocardial infarction, heart failure, community acquired pneumonia, and pregnancy and related conditions.

In addition to the current core measures, JCAHO is developing new measure sets that address surgical infection prevention, intensive care unit care, pain management, and inpatient pediatric asthma. JCAHO expects to make the new sets available over the next six to twenty-four months. Additional information may be found at http://www.jcaho.org/news+room/news+release+archives/jcaho_072503.htm.

Random Unannounced Survey Performance Areas Revised for 2004
JCAHO has revised the fixed and variable performance areas evaluated during a Random Unannounced Survey (RUS) for 2004. Under the current accreditation process, performance areas reviewed during an RUS are at the grid element (performance category) level. The revision will require that, beginning in 2004, performance will be evaluated in certain critical focus areas: process, systems, or
structures in a healthcare organization that significantly impact the quality and safety of care. The 2004 fixed performance areas will be staffing, infection control, medication management, and Goals relevant to an organization’s care and services.

**JCAHO Standards for Lung Volume Reduction Surgery**

JCAHO and CMS plan to work together to improve the quality and safety of care for patients undergoing LVRS. During 2004, JCAHO intends to develop LVRS standards for hospitals and lung transplant centers under its Disease-Specific Care Certification Program. The draft LVRS standards will be made available for public comment before they are finalized.

CMS will provide coverage for this procedure for certain Medicare beneficiaries. Hospitals must be accredited for LVRS in order to receive federal reimbursement.

**Shared Visions-New Pathways Update**

JCAHO implemented two components of its new accreditation process, the periodic performance review (PPR) and the priority focus process (PFP). In December 2003, JCAHO announced that it had completed pilot testing of the new accreditation process at twenty-five sites. The results indicate that all sites found the new accreditation process to be an improvement over the current process.

Under the PPR process, accredited organizations must conduct a mid-cycle self-assessment against applicable JCAHO standards, develop a plan of action to address any areas of noncompliance, and identify measures of success for validating resolution of the identified problem areas when the organization undergoes its on-site survey eighteen months later. Organizations can complete and submit the PPR information via JCAHO’s secure extranet site “Jayco.” Accredited organizations can access “Jayco” by going to the JCAHO home page and clicking the “Jayco” icon found in the “Easy Access” area of the home page.

In the usual PPR process, organizations are expected to share the mid-cycle assessment information with JCAHO. However, in response to organizations’ legal concerns about submitting, and thus the potential discoverability of PPR information, JCAHO is offering two options to address these concerns while maintaining the integrity of the PPR process. The first allows an organization to perform the mid-cycle self-assessment, develop a plan of action and measures of success, and attest that it has completed these activities, without actually submitting the information to JCAHO. The organization would then provide its measures of success to JCAHO for assessment during its complete on-site survey. Under the second option, an organization need not conduct a mid-cycle self-assessment. Rather, the organization would undergo an on-site survey that is one-third the length of a typical survey at the mid-cycle point. The organization would be responsible for a fee to cover the cost of the mid-cycle survey.

PFP is a data-driven tool that will help focus survey action on issues most relevant to patient safety and quality of care at the specific healthcare organization being
surveyed. Accredited organizations will receive access to organization-specific PFP information and extranet-based PPR information approximately fifteen months after their last triennial survey, and then again one to two weeks prior to their complete on-site survey.

**JCAHO Approves Strengthened Infection Control Standards**
JCAHO recently approved revised standards to help prevent the occurrence of deadly healthcare-associated infections. Accredited organizations will be expected to, among other things, incorporate an infection control program, perform ongoing assessments to identify the risk of acquisition and transmission of infectious agents, and effectively implement infection prevention and control processes. The requirements for ambulatory care, behavioral healthcare, home care, hospital, laboratory, and long term care organizations will take effect January 2005.

**New Medical Staff Chapter Element of Performance**
The Standards and Survey Procedures Committee approved a new element of performance for the medical staff chapter (standard MS 4.20) for hospitals that requires a listing within the organization of the privileges of each physician assistant or advanced practice nurse. The new element also makes each licensed independent practitioner responsible for knowing the privileges of those practitioners with whom they collaborate or supervise.

**New Managing Patient Flow Standard**
In an effort to effectively address overcrowding that can result in patient care quality and safety issues, JCAHO created a new standard on managing patient flow (LD 3.4) that promotes effective patient flow throughout the hospital. The standard will be effective January 1, 2005.

**Home Care-Specific National Patient Safety Goals**
The JCAHO Board of Commissioners approved 2004 NPSGs that contain modified language to make the goals more relevant to the home care field. Effective immediately, Phase I of the home care NPSGs leaves goals 2 and 7 unchanged, but deletes goal 4 (eliminating wrong site surgery). Phase II, which includes identifying and implementing new program-specific evidence or experience-based goals and requirements, has a proposed effective date of January 1, 2005.

**Tailoring Requirement Eliminated for Assisted Living Facilities**
Effective January 1, 2004, assisted living accreditation is optional and independent of other organization components. Complex organizations (such as hospitals or nursing homes that have assisted living residences) may continue to seek, but will not be required to have, their assisted living facilities accredited.

**2005 Office-Based Surgery Standards Field Engagement**
The standards for office-based surgery practices have been rewritten with the goal of identifying opportunities to simplify compliance activities, improve clarity, eliminate
redundancy within the standards, and strengthen links to patient outcomes. The new standards are expected to be effective January 1, 2005.

**JCAHO’s Primary Stroke Center Certification Program**
JCAHO, in collaboration with the American Stroke Association, has developed an advanced Disease-Specific Care Certification Program that will provide the first national certification program to evaluate stroke care provided by hospitals.

**JCAHO Launches Expanded Quality Check**
In January 2004, JCAHO launched its revamped quality check, the online listing of accredited organizations and their accreditation status. The new quality check includes tailored and expanded search capabilities and allows users to indicate whether they are consumers or healthcare professionals, allowing healthcare professionals access to more detailed information.

**III. REGULATORY UPDATE**

**DHHS OIG Issues Guidance for Medicare-Endorsed Discount Drug Card Sponsors**
The Department of Health and Human Services Office of Inspector General (OIG) issued guidance on the applicability of the Anti-Kickback Statute to the sponsors’ proposals to pay network pharmacies for certain education and outreach services, including enrollment assistance. The OIG stated that such payment arrangements may implicate the Anti-Kickback Statute and cautioned sponsors to review the arrangements with pharmacies to ensure that improper payments are not being made to influence pharmacies to direct beneficiaries to a particular drug card. Because of the prominence of the pharmacy benefit programs under the Medicare Modernization Act of 2003, the OIG stated that it intends to monitor the sponsor funded education and outreach programs.


**OIG Issues Alert on Added Charges for Covered Services**
The DHHS OIG issued an alert cautioning physicians not to bill Medicare beneficiaries for services that are already covered by Medicare. Responding to reports that physicians are asking beneficiaries for additional payments for covered services, OIG cited an example of a settlement with a physician who asked beneficiaries to pay an annual fee of $600 for certain services allegedly covered by Medicare. The OIG reminded physicians of the potential penalty associated with charging beneficiaries for services already covered by Medicare.

CMS Publishes Stark II/Phase II Interim Final Rule
CMS published the long-awaited Stark II/Phase II interim final rule, which has many significant revisions and additions to the Stark physician self-referral prohibition. Among the many revisions, the interim final rule establishes new exceptions to the physician self-referral prohibition and sets forth certain permissible investment and compensation arrangements. The interim final rule interprets statutory exceptions for rental of space and equipment, employment relationships, personal services, and physician recruitment. In addition, the interim final rule revises the definition of compensation to allow common percentage compensation arrangements, allows greater flexibility with the academic medical center exception, creates exceptions for Medicaid managed care plans, and professional courtesy arrangements.


CMS Issues Guidance on MMA Mandated Specialty Hospital Moratorium
CMS issued a one-time notification detailing plans to implement a moratorium on physician investment in and referrals to certain specialty hospitals mandated by the MMA. The moratorium, which became effective on December 8, 2003, the enactment date of the MMA, applies to hospitals that are primarily or exclusively engaged in the care or treatment of patients with cardiac or orthopedic conditions, patients in surgical procedures, or patients receiving other specialized services CMS may designate. Specialty hospitals under development as of November 18, 2003, are excluded from the moratorium. A hospital that questions whether it qualifies for an exclusion is requested to seek an advisory opinion with the OIG.


CMS Issues Instructions Revising Reassignment Rule
In Transmittal 111, CMS issued instructions revising the rule on reassignment. The Transmittal instructs Carriers to make payment to an entity that submits a claim for services provided by a physician or other person under a contractual arrangement regardless of where the service is provided. The contractual arrangement between the entity and the person providing the service should include the following program integrity safeguards: (1) joint and several liability for any overpayment relating to such a claim, and (2) unrestricted access to the claim by the person providing the services.


DHHS Issues Guidance on Offering Discounts to Uninsured Patients
The DHHS OIG provided guidance on hospital billing and collection practices related to the uninsured and underinsured. Responding to industry concerns, the guidance stated that Medicare rules do not prohibit hospitals from offering discounts to uninsured patients who are unable to pay their bills, so long as the discounts are not associated with referrals of federal healthcare program business. According to the
guidance, hospitals may (1) reduce or waive cost-sharing obligations for financially needy patients, (2) waive collection of charges to an indigent if it is pursuant to the hospital’s indigent policy, and (3) forgo collection efforts aimed at indigent or medically indigent patients.

**Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills** (Dep’t Health and Human Servs. Office of Inspector Gen., Guidance Feb. 19, 2004).

**CMS Implements MMA Changes to Payment for Ground Ambulance Services**
CMS published instructions implementing changes to the Medicare payment for ground ambulance services. The MMA provides for the establishment of a floor amount for the fee schedule portion of the payment, increased payments for urban and rural services, and increased payment for ambulance transports originating from certain low-density population areas. In addition, the Transmittal implements the MMA provision that establishes a 25% bonus on the mileage for the ground miles fifty-one miles or greater, and the bonus mileage applies to services furnished July 1, 2004, through December 31, 2008. **Transmittal No. 88** (Dep’t Health and Human Servs. Ctrs. for Medicare and Medicaid Servs. Feb. 6, 2004).

**CMS Updates National Coverage Determination Process**
CMS published a notice updating the CMS’s internal procedures for developing a National Coverage Decision (NCD). Some of the updates include: (1) establishing a separate process for beneficiaries who qualify as aggrieved parties under § 522 of BIPA, (2) distinguishing the reconsideration process from an initial request for an NCD, (3) updating the elements that constitute a complete formal request to reflect best practices, and (4) clarifying that all currently available evidence must be adequate for CMS to conclude that the item or service is reasonable and necessary. The notice becomes effective on October 27, 2003. **Medicare Program; Revised Process for Making National Coverage Determinations**, 68 Fed. Reg. 55634 (Dep’t Health and Human Servs. Sept. 26, 2003).

**OIG Proposes to Modify Its Permissive Exclusion Authority**
The DHHS OIG published a proposed rule that would amend its permissive exclusion authority in 42 C.F.R. § 1001.701. In an effort to address the narrow situation in which providers are charging Medicare and Medicaid substantially more than they charge a majority of their other customers for the same items or services, the OIG proposed to define the terms “substantially in excess” and “usual charges,” and to clarify the “good cause” exception. The proposed rule has relevance for items and services that are based on the provider’s charges or costs, including clinical laboratory services, durable medical equipment, medical supplies, and drugs. The OIG, however, excludes from the proposed rule the physician fee schedule, stating that the fee schedule is developed independently by the CMS and is subject to annual notice and comment. **Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims**
CMS Publishes EMTALA Final Rule
CMS published the long-awaited final rule clarifying the obligations of physicians and hospitals under the Emergency Medical Treatment and Labor Act (EMTALA). The final rule made revisions to the following areas: seeking prior authorizations from insurers for services, emergency patients presenting at off-campus outpatient clinics that do not routinely provide emergency services, the applicability of EMTALA provisions to hospital inpatients and outpatients, the circumstances under which physicians must serve on hospital medical staff “on-call” lists, and the responsibilities of hospital owned ambulances. Significantly, the final rule provides that patients must receive appropriate screening and treatment, regardless of their ability to pay.


National Correct Coding Initiative Posted on CMS Web Site
On September 2, 2003, CMS began posting on its Web site the automated edits used to identify questionable claims and adjust payments accordingly. These edits, known as the National Correct Coding Initiative (NCCI), identify pairs of services that should not be billed by the same physician for the same patient on the same day. The posting of the NCCI is an effort by CMS to ensure that Medicare does not pay twice for the same service or for duplicative services. View the initiative online at http://www.cms.hhs.gov/medlearn/ncci.asp.

CMS Publishes Final Rule Requiring Electronic Submission of Cost Report for Certain Types of Facilities
CMS published a final rule that will require hospices, organ procurement organizations, rural health clinics, federally qualified health centers, community mental health centers, and end-stage renal disease facilities to submit cost reports in electronic format beginning in May 31, 2005. CMS states that it will not reject any electronic cost report during the initial phase-in period. Instead, providers filing noncompliant cost reports will be given an opportunity to correct any problems with electronic submission. If the requirement causes financial hardship, providers may request a waiver of the requirement.

CMS Plans to Accept Noncompliant Electronic Transactions Beyond October 16 Compliance Deadline
Citing unacceptably low numbers of compliant electronic claims being submitted, CMS announced, on September 23, 2003, that it would implement a contingency plan to accept noncompliant electronic transactions after the October 16, 2003, deadline for compliance with the Health Insurance Portability and Accountability Act Transactions and Code Set standards. Under the contingency plan, CMS will continue to accept and process claims in the electronic formats now in use, ensuring continued processing of claims from providers that will not meet the deadline and thus giving the providers additional time to achieve compliance. CMS plans to regularly reassess the readiness of its trading partners to determine the expiration date of the contingency plan.

CMS Issues FY 2004 Update of IPPS
CMS published a final rule announcing a 3.4% increase in payment to acute-care hospitals under the inpatient prospective payment system (IPPS). Some of the payment provisions include: (1) expanding the post-acute care transfer policy by applying it to twenty-one diagnosis-related groups (DRGs), (2) establishing the outlier threshold amount at $31,000, down from the proposed amount of $50,645, (3) using the FY 2000 wage data to update the wage index for FY 2004, and (4) approving certain new technologies for add-on payments.


CMS Increases Payments Rates for Medicare Advantage Health Plans
CMS, on January 16, 2004, announced a significant increase in payment rates for Medicare Advantage (formerly known as Medicare+Choice) health plans. CMS mandates that the increases be used to not only support improvements in services but also to lower costs for beneficiaries. Specifically, managed care organizations must use the increased funds to reduce beneficiary premiums and co-pays, enhance benefits, and expand the network of providers available to beneficiaries. The increase gives those managed care organizations that previously announced their departure from Medicare Advantage an opportunity to remain in the program. The increase was included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and became effective on March 1, 2004.

CMS Modifies Payment for Hospital Outpatient Services
CMS issued an interim final rule that implements provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that affect Medicare payment of hospital outpatient services. The interim final rule revises payments to rural hospitals and payments for certain radiopharmaceuticals, drugs, and biologicals that were published in the hospital outpatient prospective payment system final rule in November 2003. The interim final rule extends payments to small rural hospitals by two years and also allows sole community hospitals in rural areas to become eligible for these special payments. In addition, the interim final rule changes the methods for
drug payment in hospital outpatient departments, affecting the methodology for paying for pass-through and non-pass-through drugs.


**CMS Increases 2004 Payment Rate for Physicians**
CMS, on January 6, 2004, issued an interim final rule that will increase Medicare payments to physicians by an average of 1.5% for calendar year 2004. The interim final rule is published pursuant to the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, and replaces the 4.5% reduction in physician payment that was published in November 2003. The increase became effective on January 1, 2004.

**CMS Changes Medicare Requirements for Rural Health Clinics**
CMS published a final rule making changes to Medicare certification and payment requirements for rural health clinics. The following changes are contained in the final rule: (1) changing the definition of a qualifying rural shortage area in which a rural health clinic must be located, (2) limiting waivers of certain non-physician practitioner staff rules, (3) imposing payment limits on provider-based rural health clinics and prohibiting commingling of a rural health clinic with another entity, and (4) requiring rural health clinics to establish a quality assessment and performance improvement program that exceeds regulations. The final rule became effective on February 23, 2004.


**CMS Announces the Availability of Medicare Drug Discount Card Programs**
CMS issued an interim final rule that will allow eligible beneficiaries to enroll in a Medicare-approved prescription drug discount program beginning in spring 2004. The interim final rule is the first regulation implementing the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (Act). An important feature of the drug discount card programs is the assistance to low-income beneficiaries. Under the Act, eligible low-income beneficiaries will receive payment of $600 of the cost of covered discount card drugs. Medicare beneficiaries will have a choice of at least two Medicare-approved drug discount cards and will be able enroll in one of them. The enrollment cost cannot exceed $30 annually. The drug discount card benefit will continue until 2006, when the Medicare prescription drug benefit becomes effective. The drug discount card benefit is expected to be available through many sources, including pharmaceutical benefit managers, insurers, retail pharmacies, and Medicare+Choice plans.

CMS Establishes New Payment System for Inpatient Psychiatric Facilities
Implementing §124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, CMS proposed a rule that would replace the current cost based payment system with a per diem prospective payment system for inpatient hospital services provided in psychiatric hospitals and psychiatric units of hospitals. Under the proposed rule, the per diem rate will be calculated based on the sum of average routine operating, ancillary, and capital costs for each patient day of psychiatric care.


CMS Publishes Final Rule Allowing Medicare Beneficiaries to Challenge Medicare Coverage Decisions
Implementing portions of §522 of the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000, CMS published a final rule creating a new process for challenging national coverage determinations (NCDs) and local coverage determinations (LCDs) by certain Medicare beneficiaries. The final rule allows beneficiaries to challenge LCDs before an administrative law judge. A DHHS appeals board then has the jurisdiction to review appeals involving NCDs and LCDs. The board’s decision can be challenged in a federal court after the exhaustion of the administrative appeals. The new right to appeal coverage determinations will be distinct from the existing beneficiary right to adjudicate Medicare claims.


CMS Allows Use of Paid Feeding Assistants in Long Term Care Facilities
In order to provide more long term care facility residents help in eating and drinking and to reduce the incidence of unplanned weight loss and dehydration, CMS published a final rule permitting the use of paid feeding assistants to supplement the services of certified nurse aides in long term care facilities. Under the final rule, states are required to approve training programs for feeding assistants with the federal requirements providing the minimum standards. Upon completion of a state approved training program, feeding assistants may provide services to residents under the supervision of a registered nurse or licensed practical nurse. The final rule became effective on October 27, 2003.

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I. BANKRUPTCY

U.S. Court in Delaware Bars Qui Tam Relators from Challenging Approved Settlement and Bankruptcy Confirmation Order

In 1998, relators in a qui tam action alleged that Vencor, Inc. (Vencor), and Behavioral HealthCare Corporation (BHC) knowingly submitted false Medicare claims to the government. The government reached a settlement with Vencor and BHC in 2001 regarding such claims, and the District Court of California approved the plan. Relators were not included in the settlement. Vencor had previously filed for bankruptcy in 1999 and two proofs of claim were filed: one by relators for the qui tam action and one by relators’ attorney for his fees related to the action. In 2001, Vencor filed a reorganization plan with the U.S. Bankruptcy Court to settle claims filed by the government. At this time, relators filed suit in the U.S. District Court of Delaware, objecting to the reorganization plan and earlier settlement plan. Relators argued that the government lacked the authority to intervene and bar their claims.

The U.S. District Court for the District of Delaware dismissed both claims because relators had failed to appeal the orders through the proper court systems. The court dismissed the claim that the government’s settlement prohibiting further claims by the relators was unauthorized based on lack of federal appellate jurisdiction. The court also dismissed the claim to vacate the certification order of the bankruptcy court, holding that relators should have, and could have, petitioned to vacate the order by appealing the original order within a timely manner.


This case shows the importance of appealing judicial orders in the proper court systems.

II. TAXATION

U.S. Court in Minnesota Says Employer of Medical Residents Doesn’t Owe FICA Taxes on Stipends

The Mayo Foundation (Foundation) is the parent of the various “Mayo” entities, among them the Mayo Graduate School of Medicine (MGSM). Through MGSM, the Foundation operates residency and fellowship programs for medical school graduates. The residency program involves significant clinical patient-care experience under the supervision of Foundation-employed staff physicians, along with textbook and journal reading, and lectures and conferences. The residents pursued various clinical disciplines periodic rotations through the Mayo clinics and hospitals. Through its agent, the Mayo Foundation for Medical and Educational Research, the Foundation
paid residents a stipend. In 1999, the Foundation requested, and the IRS granted, a refund of FICA taxes on medical resident stipends on the basis of the so-called “student FICA exception,” which requires a student to be employed by a “school, college, or university.” The IRS later reconsidered and sued to recover the refund.

The U.S. District Court for the District of Minnesota ruled that the student FICA exception applied and that the Foundation was thus entitled to the refund. The court rejected the IRS’ position that the Foundation could not be a “school, college, or university” if its “primary purpose” is not educational, i.e., it is not a medical school. Instead, relying on the explicit directive of the regulations to interpret “school, college, or university” in the commonly accepted sense, the court found that the Foundation qualified as a “school” because it served to teach particular skills—specifically, training residents to be physicians through hands-on clinical activities. The court also found that the Foundation was the residents’ employer, that the residents perform service pursuant to their studies, and that the residents enroll and regularly attend classes. United States v. Mayo Foundation for Med. and Educ. Research, 282 F. Supp. 2d 997 (D. Minn. 2003).

This case is significant because it rejects the IRS’ narrow interpretation of the student FICA exception, opening up the exception for most teaching hospitals operating a residency program, not just medical schools.

Fourth Circuit Finds That West Virginia State Tax Isn’t Impermissible Indirect Tax on Carriers Insuring Federal Employees

Under the Federal Employees Health Benefits Program, the federal government contracts with health insurance carriers to provide health insurance to federal enrollees. Both the government and enrollees make payments to the Federal Employees Health Benefits Fund (Fund), which in turn disburses payments to carriers. Under 5 U.S.C. § 8909(f), no tax may be imposed on a carrier directly or indirectly on payments from the Fund. The federal government sued West Virginia to challenge its state tax on gross receipts received by healthcare providers. Although imposed on hospitals, the tax could be passed on to carriers, including for services to federal enrollees. The district court granted the federal government summary judgment on the basis that the West Virginia tax was an indirect tax on carriers.

The Fourth Circuit reversed, ruling that the West Virginia tax is not an indirect tax on carriers. Lacking a definition of “indirect tax” in the statute or regulations, the appeals court concluded that the common definition does not encompass the pass-through of the costs of a tax. Placing an economic burden, but not the legal incident of the tax, on carriers did not rise to the level of an indirect tax. United States v. West Virginia, 339 F.3d 212 (4th Cir. 2003).

The Fourth Circuit held that a West Virginia health care gross receipts tax, the cost of which would be passed-through to health insurers of federal employees, wasn’t “indirect tax” on such insurers prohibited by federal law.
Fifth Circuit Vacates District Court’s Summary Judgment Ruling in Favor of § 501(c) Health System Engaged in 50/50 Whole-Hospital Joint Venture

St. David’s Health Care System, Inc. (St. David’s), a § 501(c)(3) entity, entered a whole-hospital joint venture (Partnership) with a for-profit affiliate of HCA. St. David’s and HCA shared 50/50 representation on the Partnership’s governing board. Another HCA affiliate was granted a long-term management contract. After audit, the IRS revoked St. David’s tax-exemption on the basis that St. David’s had conferred excessive private benefit on HCA in the form of control over the Partnership. St. David’s paid back taxes under protest and filed a refund claim. On summary judgment, a federal district court held that St. David’s continued to qualify under § 501(c)(3), rejecting IRS assertions that St. David’s lacked a community board or, in view of certain contractual safeguards, that St. David’s lacked sufficient control over the Partnership.

The Fifth Circuit vacated the district court’s summary judgment ruling on the basis that material facts were still in dispute concerning the Partnership’s effect on St. David’s qualification under § 501(c)(3). Although the appeals court agreed that the lack of a traditional community board was not fatal, it found that St. David’s could not merely point to safeguards in the Partnership documents to establish that it retained sufficient control over the Partnership. Rather, control must be determined by examining the actual facts underlying the ability of St. David’s to influence the Partnership’s operations and enforce its rights. The appeals court also provided further guidance as to how charitable purpose provisions and charitable purpose enforcement rights are relevant to “control” over a joint venture.

St. David’s Health Care Sys., Inc. v. United States, 349 F.3d 232 (5th Cir. 2003).

The significance of this case is that the Fifth Circuit supported the IRS’ position regarding required control by § 501(c)(3) entities participating in joint ventures with for-profit persons but added that determining control requires an “on-the-ground” analysis of actual facts.

South Dakota Supreme Court Approves Imposition of Constructive Trust Law on Proceeds of Sale by Nonprofit Hospital to Keep Assets in the Local Community

Banner Health System (BHS), a nonprofit hospital, sold its assets to another nonprofit organization. The South Dakota attorney general (AG) sought to apply constructive trust law, in lieu of South Dakota nonprofit corporation law, in order to require that the assets of the sale remain in the local community. BHS filed an action in federal district court against the AG, seeking a declaratory judgment that the asset sale was governed solely by South Dakota nonprofit corporation law. The AG sought to dismiss the action, but the U.S. District Court denied the motion and certified the question of law to the South Dakota Supreme Court.

The South Dakota Supreme Court held that an implied or constructive charitable trust could be imposed on the assets in specified circumstances, namely when a nonprofit organization has received local donations to benefit the local community and later
attempts to use the assets of the organization to benefit non-locals. The judgment was based on three theories: (1) the nonprofit hospital would be unjustly enriched by the sale of assets and removal of the proceeds from the local communities at the expense of the local communities, (2) the nonprofit hospital breached its fiduciary duty by utilizing trust (hospital) property for its own benefit or by taking part in an action that would be adverse to the trust’s beneficiaries (the local community), and (3) the nonprofit corporation improperly amended its articles of incorporation and bylaws because the hospital was, in essence, changing the purpose of the assets from a local charitable purpose, voiced to the community when the assets were collected, to a different charitable purpose that would not benefit the community.


*This case illustrates that an implied or charitable trust, rather than nonprofit corporation law, can be imposed on assets of a sale between nonprofit entities.*

**Tax Court Holds that IRC § 530’s Requirement for Excepting Employment Tax Liability Does Not Require Timely Filings**

Medical Emergency Care Associates (MEC) provided physician staffing to hospitals for emergency care physicians. The contracts MEC had with its physicians were entitled “Independent Contractor Agreements.” The IRS later reclassified some of the physicians hired by MEC as employees. Thereafter, MEC sought employment tax relief under Internal Revenue Code § 530 with regard to the individuals reclassified as employees. Section 530 allows relief from employment tax liability, notwithstanding the employee-employer relationship, if three requirements are met: (1) the taxpayer cannot treat the individual as an employee for any period of time, (2) all federal tax returns must be filed with the individual in question not being treated as an employee, and (3) the taxpayer must have a reasonable basis for not treating the individual as an employee. The IRS concluded that MEC had met requirements (1) and (3) but denied MEC the § 530 exception because MEC failed to meet requirement (2). MEC had not filed all of its tax returns in a timely manner during the period for which it was seeking relief. As a result, the IRS argued that the second requirement had not been met because the statute implied that the returns be timely filed.

The U.S. Tax Court disagreed with the IRS, stating that the statute contained no language requiring timeliness of filing and only required that the individual not be treated as an employee on any returns. Accordingly, MEC was granted its requested relief.


*This case shows that the IRS is becoming more vigilant in looking at the employee-independent contractor distinction, and is more willing to recharacterize independent contractors as employees.*

**IRS Tax Exempt Entities Section Grants Tax Exemption to Nonprofit Association Affiliated with For Profit Organizations Through Joint Ventures**
A nonprofit association filed a petition in U.S. Tax Court after it received an adverse determination from the IRS, finding the association ineligible for tax-exempt status. See. However, after filing the petition, the Tax Exempt Section reconsidered the application and granted the association tax-exempt status dated back to 1995. The petition was thus dismissed. The IRS did not issue formal guidance for similar entities but, in light of this case, a nonprofit entity affiliated with for-profit entities in a properly structured affiliation can obtain or maintain its tax-exempt status if there are proper restrictions in place guaranteeing the profits are used for a charitable purpose. In the instant case, the nonprofit entity was involved in different joint ventures with three for-profit entities: a limited partnership in which the nonprofit was the general partner and the for-profit was a limited partner, another organization in which the for-profit owned only 1% of the joint venture with no management control, and another organization in which the nonprofit and for-profit equally managed the joint venture.

John Gabriel Ryan Ass’n v. Commissioner, No. 16811-02X (Oct. 2002).

This case shows that a nonprofit entity affiliated with for-profit entities in a properly structured affiliation can obtain or maintain its tax-exempt status if there are proper restrictions in place.

Non-Hospital Healthcare Providers Dismiss Case before the United States Supreme Court Challenging a Florida Tax on Non-Hospital Providers

Four classes of non-hospital healthcare providers consisting of ambulatory surgical centers, diagnostic-imaging centers, radiation therapy centers, and clinical laboratories brought an action against the Agency for Health Care Administration (Agency), challenging a statutory assessment under the Florida Public Medical Assistance Trust Fund (PMATF). This Fund imposed tax on the gross receipts of certain non-hospital healthcare providers and provides increased Medicaid reimbursements only to hospitals. The non-hospital healthcare providers claimed that the tax violated both the Equal Protection and Due Process Clause under the Fourteenth Amendment of the Constitution. The Circuit Court for Leon County declared the statute allowing PMATF assessment unconstitutional and enjoined the Agency from imposing further assessments thereunder. The Agency then filed an interlocutory appeal. On appeal, Florida’s First District Court of Appeals reversed and remanded the lower court ruling. The petitioners filed a writ of certiorari but later dismissed the challenge by agreement of the parties.


Wisconsin Appeals Court Finds Clinic Not Entitled to Property Tax Refund Because It Failed to Show Use of Property was Exclusively for Benevolent Purposes

The Wisconsin Court of Appeals affirmed a trial court’s summary judgment decision denying Marshfield Clinic's (Marshfield) request for a property tax refund. Marshfield, a nonprofit corporation that is exempt from federal income tax, owns three healthcare clinics in Eau Claire, Wisconsin. The trial court found that Marshfield had failed to meet its burden of showing exclusive, benevolent use of its property. Although
Marshfield engaged in benevolent activities, it did not provide sufficient itemized documentation of the uses of the property and did not show that the medical care provided to paying patients was merely incidental to exempt purposes. The appeals court found that Marshfield had failed to present any evidence that would create a genuine issue of material fact as to whether Marshfield exclusively uses the property for research, education, or treatment of deserving destitutes. **Marshfield Clinic v. City of Eau Claire**, 674 N.W.2d 680 (Wis. App. 2004).

*This case illustrates the importance of properly documenting a facility’s use for benevolent purposes.*

**Iowa Appeals Court Holds Assisted Living Facility Owned by Municipal Hospital Exempt from Taxation**

Orange City Municipal Hospital (hospital), an agency of the City of Orange City, opened Landsmeer Ridge Retirement Community (Landsmeer), an assisted and independent living facility. Landsmeer, which is licensed by the Iowa Department of Elder Affairs, admits only patients who can pay for their care. The Board of Review of Sioux County (Board) twice denied Landsmeer tax-exempt status, and the district court affirmed that decision. The hospital appealed.

The Iowa Court of Appeals reversed, holding that Landsmeer had a public use and was not being held for a pecuniary profit; therefore, the statute authorizing exemption for municipal property applied. The appeals court determined that Landsmeer serves a very significant need in the community because it is the only assisted or independent living facility in Orange City. The appeals court rejected the Board’s contention that Landsmeer did not serve a public purpose because it did not subsidize low-income residents. In addition, the appeals court concluded that the fact that a municipality receives revenue from a property does not subject the property to taxation, and in this case, any profits were returned to the hospital for its operation and maintenance. **Orange City Mun. Hosp. v. Bd. of Review of Sioux County**, 672 N.W.2d 333 (Iowa App. 2003).

*The court allowed tax exemption for a facility that did not subsidize low-income residents because the facility was municipally owned and was not being held for pecuniary profit.*

**Massachusetts Appeals Court Affirms Denial of Property Tax Exemption, Finding Foundation Failed to Prove Medical Clinic Was Operated for Charitable Purposes**

Sturdy Memorial Foundation, Inc. (Foundation), applied for abatement of real estate taxes for 1996 and 1997 and for 1998 through 2000, claiming a statutory charitable tax exemption for property that the Foundation owned and leased to a medical clinic operated by Sturdy Memorial Associates (Sturdy). The applications were denied, and the Appellate Tax Board (Board) affirmed, finding the Foundation was a charitable organization but Sturdy was not. The Foundation appealed and requested additional
findings by the Board that Sturdy’s income did not meet its expenses and the Foundation made up the difference, that the salaries of Sturdy’s physicians were less than market rate and were not related to income generated by the clinic, and that 25% of Sturdy’s patients were referred to Sturdy Memorial Hospital. The Board denied the Foundation’s request for additional findings, and the Foundation appealed. The appeals court remanded the case to the Board, explaining that, for a medical practice to have a charitable purpose it must have an absolute prohibition against private inurement and the community at large must benefit from the operation of the clinic. On remand, the Board determined that Sturdy’s operation at a deficit was not conclusive evidence that it was a charity because the deficiency was caused by Sturdy’s payment of physician expenses and that there was no evidence to support the Foundation’s contention that the physicians were paid below market rates.

On appeal following the remand, the Massachusetts Court of Appeals found that the evidence that the bonuses were paid based on productivity supported a finding that the income was used for non-charitable purposes. The appeals court affirmed the Board’s determination that Sturdy was not operated for a charitable purpose and thus did not qualify for the tax exemption.


A Massachusetts appeals court found that payment of physician bonuses based on productivity supported a finding that the income was used for other than charitable purposes, and therefore a purported charitable medical clinic was denied a state-level property tax exemption.

**IRS Issues Intermediate Sanctions PLR Concerning Issuance of Subordinated Bonds to Joint Venture Including Medical Staff**

The IRS has ruled that a tax-exempt hospital that issues subordinated bonds to a limited liability company (LLC) owned in part by members of the medical staff who serve on the hospital’s board has met the comparability requirement of the rebuttable presumption standard in the intermediate sanctions regulations. The hospital board (with the members of the medical staff not participating in the discussion or vote) approved a bond issue in which 90% consisted of senior bonds and 10% consisted of subordinated bonds. The subordinated bonds only pay interest if certain financial performance targets are met, but unpaid interest accrues and is due upon maturity of the bonds. Forty percent of the subordinated bonds will be sold to an LLC owned by members of the medical staff, including members who serve on the hospital board. The LLC will be managed by an affiliate of the hospital, and its sole purpose is to hold the bonds. LLC members pay a fixed price for each unit. The LLC will use the proceeds to buy subordinated bonds and will distribute interest to its members pro rata. Physician members of the LLC are bound by a non-compete and can be bought out at 90% of par plus accrued interest for breaching contracts with the hospital.

The IRS required the hospital to adopt a new conflicts of interest policy and to represent that the sale of bonds did not violate the federal Anti-Kickback Statute. The
IRS ruled that the auction process for setting the interest rate of the subordinated bonds is a common commercial competitive bidding process for independently and fairly determining the coupon rate for bonds that are sold to the public and accordingly meets the definition of an “open and competitive bidding process” under Treas. Regs. 53.4958-6(c)(2)(i). The IRS did not rule on whether the LLC was a disqualified person or whether the hospital board had satisfied the other requirements of the rebuttable presumption. Moreover, the IRS did not reach any specific conclusion about whether there was an excess benefit transaction. 


In PLR 200413014, the IRS determined that the hospital board relied on proper comparability data for purposes of establishing the rebuttable presumption under the intermediate sanctions regulations, by relying on an auction process for setting the interest rate of subordinated bonds issued to an LLC composed of members of the medical staff of an exempt hospital, including certain physicians on the board of the exempt hospital.

IRS Issues Revenue Ruling 2004-51 Concerning Nonprofit/For-Profit Ancillary Joint Ventures

The IRS considered a joint venture between a tax-exempt university and a for-profit company specializing in interactive video training programs. The venture was structured as a limited liability company (LLC) taxable as a partnership, where the university and the for-profit company each owned 50% of the membership interests, and each had the right to appoint three of the six directors on the LLC’s governing board. Governing documents gave the university exclusive powers to approve the curriculum, training materials, and instructors, and to determine the standards for completion of the seminars. The documents required all contracts and transactions between the LLC and the respective members and third parties to be at arms length and at fair market value, and prohibited the LLC from engaging in activities that would jeopardize the university’s tax exemption. The ruling assumes that the LLC operates consistent with its governing documents. Importantly, the fact pattern also assumes that the university’s participation in the venture will be an insubstantial part of its activities within the meaning of Treas. Regs. § 1.501(c)(3)-1(c)(1).

The IRS ruled: (1) that the university will continue to qualify for tax exemption under § 501(c)(3), and (2) that the university would not be subject to unrelated business income tax with respect to the income stream from the venture. See Rev. Rul. 98-15, 1998-1 C.B. 718, Redlands Surgical Services v. Comm’r, 113 T.C. 47 (1999), aff’d, 242 F.3d 904 (9th Cir. 2001), and St. David’s Health Care System v. U.S., 349 F.3d 232 (5th Cir. 2003). The IRS determined that, although the activities of the venture will be attributed to the university, the university’s participation, alone, would not affect its tax exemption. With respect to the unrelated business income tax issue, the IRS determined that the university’s participation in the venture was substantially related to the exercise and performance of its exempt function. The IRS relied on the reserve powers retained by the university, the provisions requiring arms length, fair market value transactions, the proportionality of contributions and distributions, and the fact
that the venture will expand the reach of the exempt function (teacher training seminars).


*Rev. Rul. 2004-51 is the IRS’ first significant pronouncement in the area of ancillary joint ventures, as opposed to whole-hospital and similar joint ventures. The ruling describes the IRS’ approach to unrelated business income tax issues and confirms that, where the ancillary joint venture activities are insubstantial in relation to the other activities of the tax-exempt organization, the exempt organization should continue to qualify for exemption.*

**U.S. House of Representatives Chairman Thomas Calls for Examination of Tax-Exempt Status of Nonprofit Hospitals**

House Ways and Means Committee Chairman Bill Thomas (R-CA) announced that he would examine the tax-exempt status granted to nonprofit hospitals and other charitable entities. Thomas spoke on March 2, 2004, at the annual meeting of the Federation of American Hospitals (Federation) in Washington, D.C., which represents investor-owned hospitals. Approximately 61% of the nation’s nearly 5,000 community hospitals are tax-exempt, according to the American Hospital Association (AHA). Thomas indicated that his examination likely would address the following broad questions: (1) Can charitable activities be easily discerned as being different from activities of for-profit organizations?, (2) Are nonprofit entities upholding the “social compact” they originally created with the taxpayer?, (3) To what extent do not-for-profit entities duplicate the business behavior of their for-profit counterparts?

According to news reports, Thomas’ interest in tax-exempt status was prompted in part by a letter the AHA sent in December 2003 to Secretary of Health and Human Services Tommy G. Thompson, which sought clarification of potential regulatory barriers to hospitals’ offering discounted care to the uninsured and underinsured. In his reply, the Secretary flatly rejected suggestions that Department of Health and Human Services regulations require hospitals to bill all patients using the same schedule of charges, thus resulting in the uninsured paying “full price” for care while insured patients enjoy the benefit of negotiated prices. In remarks at the Federation’s meeting, Thomas described the AHA letter as a “very, very cynical” communication that did not reflect the ethic of community service that not-for-profit healthcare should ensure.


*In view of House Chairman Thomas’s stated intent to review the tax-exempt status of nonprofit hospitals, nonprofit hospitals and healthcare organizations should prepare to make their case that tax exemption is supportable on public policy grounds by looking carefully at their charity care and community benefit activities and their policies on treating and billing the uninsured.*
St. David’s Jury Verdict Approves Tax-Exempt Status of Exempt Participant in Whole Hospital Joint Venture
The jury in St. David’s Health Care System v. United States, a case on remand to the U.S. District Court for the Western District of Texas, concluded that a nonprofit healthcare system should retain its tax-exempt status even though it entered into a partnership with a for-profit healthcare entity. The decision is a defeat for the IRS, which claimed that St. David’s should forfeit its tax-exempt status because it was no longer operating exclusively in furtherance of charitable purposes after it entered into a limited partnership with HCA, Inc., in 1996.

St. David’s won a summary judgment in June 2002 that rejected the IRS’ contention that it should forfeit its tax-exempt status. St. David’s Health Care System, Inc. v. United States, No. Civ. A-01-CA-046-N, 2002 WL 1335230 (W.D. Tex. June 7, 2002). The Fifth Circuit reversed and remanded the case to the trial court. St. David’s Health Care System v. United States, 349 F.3d 232 (5th Cir. 2003). The Fifth Circuit held that, for a healthcare joint venture, the central issue was not whether the partnership meets the community benefit standard. In the court’s opinion, whether a joint venture substantially furthers a non-exempt purpose is determined by analyzing which individuals or entities control the organization, stating “when a non-profit organization forms a partnership with a for-profit entity, the non-profit should lose its tax-exempt status if it cedes control to the for-profit entity.” On remand, the jury was asked one question: whether to affirm the tax-exempt status of St. David’s The jury concluded that St. David’s should retain its exempt status.


The jury’s verdict emphasizes the strategic importance of choosing a forum in which there is a right to a jury trial in litigated tax cases generally, notwithstanding the detailed fact finding inquiries being called for by the Fifth Circuit’s appellate opinion.

III. LEGAL REPRESENTATION

U.S. Court in New York Holds Defendant Failed to Show Counsel Was Ineffective
Jose Hernandez was convicted of Medicare fraud and conspiracy and sentenced to eighteen months’ imprisonment. The appeals court affirmed the conviction. Hernandez moved in district court to set aside or correct his conviction or sentence based on ineffective assistance of counsel and newly discovered evidence.

The U.S. District Court for the Southern District of New York denied the motion, holding that counsel was not ineffective either at trial or on appeal and that purported newly discovered evidence that witness was not an employee of defendant’s company was not material and did not warrant retrial or any finding of ineffectiveness of counsel. The district court determined that counsel’s questioning of the witnesses and her decision to ask or not to ask certain questions was trial strategy. The district court
also found that counsel’s decision not to object to the admission of certain evidence was reasonable because the evidence at issue was plainly admissible. Moreover, counsel was not ineffective in representing Hernandez on appeal because there was no appealable issue and a rehearing would have been pointless because there was ample evidence to support the jury’s verdict.  

Counsel’s trial strategies do not amount to ineffective assistance simply because the strategies are unsuccessful. Rather, ineffective assistance is only actionable if it is unreasonable or prejudicial.

**U.S. Court in Illinois Holds Nursing Home Violated Medicaid Act By Requiring Personal Guarantee From Family Member As Condition to Admitting Resident**  
Meadowbrook Manor Bolingbrook (Meadowbrook), a nursing home, required David P. Carroll to sign a personal guarantee of payment for his father-in-law, James R. McDonald, whom Carroll accompanied as McDonald was admitted to Meadowbrook. The guarantee held Carroll liable if McDonald did not pay Meadowbrook its pre-arranged fees. The law firm of Freedman, Anselmo, Lindberg & Rappe (Freedman) filed suit on behalf of Meadowbrook against Carroll to enforce the guarantee. After obtaining judgment against Carroll, which was later vacated, Freedman and Meadowbrook garnished Carroll’s wages. In response, Carroll sued Freedman and Meadowbrook in district court.

The district court denied Freedman and Meadowbrook’s motion to dismiss Carroll’s claims that the personal guarantee violated the Medicaid Act and that Freedman violated the Fair Debt Collection Practice Act by trying to collect on an illegal guarantee. Specifically, the district court held that Meadowbrook’s conditioning of the admission of McDonald on a personal guarantee clearly violated the Medicaid Act, and Freedman had knowledge of this violation prior to attempting to collect on the guarantee. The district court did, however, grant Freedman and Meadowbrook’s motion to dismiss Carroll’s claim that Meadowbrook violated the Illinois Consumer Fraud Act, because the conduct did not offend public policy, and Carroll failed to allege a substantial injury.  

Personal guarantees as a condition of admission to a nursing home violate the Medicaid Act.

**U.S. Court in Connecticut Awards Medicare Beneficiaries over $300,000 For Attorneys’ Fees and Expenses in Action Finding DHHS Violated Medicare Regulations**  
After the federal district court granted summary judgment to the Connecticut State Department of Social Services and a statewide class of Medicare beneficiaries (collectively, “plaintiffs”) in three of four substantive claims regarding the failure of the
U.S. Department of Health and Human Services (DHHS) to provide written, timely, and accurate initial coverage and reconsideration determinations, plaintiffs sought attorneys’ fees and expenses under the Equal Access to Justice Act (EAJA). The district court found plaintiffs met all of the threshold requirements and awarded $309,142 in attorneys’ fees and other expenses. Plaintiffs filed their application for fees within thirty days of final judgment as required by the EAJA.

The court determined that plaintiffs were prevailing parties under the EAJA, that DHHS failed to make a strong showing that its position was substantially justified, and, finally, that no special circumstances existed that would make an award of attorneys’ fees unjust. 


The court recognized that the attorneys for plaintiffs who were found to be prevailing parties under the Equal Access to Justice Act possessed specialized skills in Medicare benefits law, and thus deserved an hourly rate above the statutory cap.

Ohio Appeals Court Rules Counsel’s Withdrawal from Medical Malpractice Case Was Not Legal Malpractice

Thomas Ruble sued Paul M. Kaufman and Jeffrey R. Wahl, claiming legal malpractice when they withdrew from the medical malpractice case that Ruble filed against Cleveland Clinic for the wrongful death of his wife, Ruth Ruble. Ruble claimed that Kaufman and Wahl did not inform him that the trial judge had determined that no additional continuances would be granted after a motion to continue the trial was filed by Kaufman and Wahl and granted by the court. The trial court granted Kaufman’s and Wahl’s motion for directed verdict, holding that the withdrawal was not legal malpractice and that Ruble failed to prove that he was damaged by the withdrawal because there was no expert opinion supporting the medical malpractice action.

The Ohio Court of Appeals affirmed the trial court’s judgment, concluding that Ruble had to prove some merit to his underlying case because there was no proof the medical malpractice claim was viable and the outcome of the medical malpractice trial would not have changed if Kaufman and Wahl had not withdrawn and therefore Ruble was not damaged.


Legal malpractice action based upon the withdrawal of plaintiff’s attorneys could not stand where plaintiff was unable to show that his underlying medical malpractice claim had some merit.
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I. CREDENTIALING AND PEER REVIEW

Sixth Circuit Finds HCQIA Immunity Applies to Both Medical and Non-Medical Personnel Involved in Peer Review

The Sixth Circuit again upheld a hospital board’s right to revoke a physician’s medical staff privileges and ruled that such decision was immune from suit under the Health Care Quality Improvement Act (HCQIA). Of interest in this case, however, was the argument by the physician plaintiff that HCQIA immunity did not apply in instances in which the review was conducted entirely by non-medical personnel. Plaintiff argued that such a review would not qualify as peer review under HCQIA. The appeals court disagreed, finding no support for the physician’s contention that the word “person” should be read as “physician.” Because the statutory language was unambiguous, an examination of legislative history was not necessary.


HCQIA immunity is available to every “person” participating in the peer review process and not just physicians.

II. LEGAL REPRESENTATION ISSUES

U.S. Court in Connecticut Awards Attorneys’ Fees and Expenses Under Equal Access to Justice Act

Attorneys’ fees and expenses under the Equal Access to Justice Act (EAJA) were awarded to Connecticut’s Department of Social Services and a statewide class of dual eligible Medicare beneficiaries (plaintiffs) who sued the Secretary of Health and Human Services for failing to provide timely and accurate written coverage and reconsideration determinations for home health services. There are four requirements for this award under EAJA: (1) the party seeking fees/expenses must file an application within thirty days of final judgment, (2) it must be a “prevailing party,” which means only that the plaintiff succeeded on “any significant issue in [the] litigation,” (3) the government failed to make a strong showing that its position was substantially justified, and (4) there were no other considerations which would make the award of fees and expenses unjust. Plaintiffs had succeeded on three of the four substantive claims, and the court noted that the government could not show that its position was substantially justified, given the court’s earlier decision that the DHHS Secretary violated both established principles of due process and the plain language of the Medicare regulations. The court also agreed to enhance the EAJA statutory cap of $125 per hour to between $325 and $375 per hour, because of the special skills in Medicare benefits law that the attorneys possessed.

The court recognized that the attorneys for plaintiffs who were found to be prevailing parties under the EAJA possessed specialized skills in Medicare benefits law, and thus deserved an hourly rate above the statutory cap.

Ohio Appeals Court Agrees That Counsel’s Withdrawal from Medical Malpractice Case Was Not Legal Malpractice

Attorneys for the husband of a deceased woman (plaintiff) determined that their two medical expert reports were legally inadequate to support a medical malpractice action. The trial court granted a continuance in order for plaintiff to identify a medical expert willing to opine that the death of plaintiff’s wife was caused by malpractice. The order granting the continuance stated that no additional continuances would be granted. When plaintiff was not able to obtain a medical expert’s opinion, his attorneys informed him the case should be dismissed. However, plaintiff refused to dismiss the case, and the attorneys requested the trial court’s consent to withdraw, which was granted. Plaintiff proceeded pro se but presented no evidence. The trial court entered a verdict for the defendant, Cleveland Clinic, which was affirmed on appeal. Plaintiff sued his original attorneys, claiming legal malpractice for their withdrawal.

The Ohio Court of Appeals, following Ohio Supreme Court precedent, held that plaintiff had to prove that there was some merit to his case. Because there was no proof that a medical malpractice claim was viable, the outcome of the trial would not have changed if the attorneys had not withdrawn. Accordingly, plaintiff was not damaged and the trial court’s judgment was affirmed.


Legal malpractice action based upon the withdrawal of plaintiff’s attorneys could not stand where plaintiff was unable to show that his underlying medical malpractice claim had some merit.

U.S. Court in New York Holds Defendant Failed to Show His Counsel was Ineffective

In August 2000, Jose Hernandez was convicted of Medicare fraud and conspiracy and sentenced to eighteen months imprisonment. The appeals court affirmed the conviction. Hernandez moved to set aside or correct his conviction or sentence based on ineffective assistance of counsel and newly discovered evidence.

The U.S. District Court for the Southern District of New York denied Hernandez’s motion. In order to prevail on a claim of ineffective assistance, a defendant must rebut a presumption that counsel’s conduct was reasonable and must show that “but for” counsel’s errors, the outcome of the trial would have been different. Hernandez claimed that, at trial, his counsel was ineffective because she (1) did not adequately cross-examine certain witnesses, (2) did not make certain objections, (3) failed to join in a motion for mistrial, (4) failed to move for a mistrial, and (5) failed to investigate
certain allegations against him. The district court determined that counsel’s decisions regarding questioning or cross-examining witnesses was trial strategy and explained that the fact that the strategy was not successful did not mean that counsel was ineffective. Moreover, failing to raise objections was not actionable because certain evidence was plainly admissible and the decision not to object was reasonable. The court also rejected Hernandez’s argument that that he should have been granted a new trial based on the discovery of new evidence. To succeed, Hernandez was required to show that the evidence was both material and could not have been discovered before or during trial. Because the evidence was not material, this claim failed.

_Counsel’s trial strategies do not amount to ineffective assistance simply because the strategies are unsuccessful. Rather, ineffective assistance is only actionable if it is unreasonable or prejudicial._

**U.S. Court in District of Columbia Awards Attorneys’ Fees Against DHHS Secretary for Bad Faith**
The Gray Panthers Fund, three national organizations, and individual Medicare beneficiaries (collectively “plaintiffs”) sued the Secretary of Health and Human Services for extending a statutory deadline for Medicare+Choice Organizations to submit information about their plans and for omitting comparison data from annual mailings as required by statute. The U.S. District Court for the District of Columbia granted summary judgment to plaintiffs, who then moved for an award of attorneys’ fees under the Equal Access to Justice Act (EAJA), 28 U.S.C. § 2412. In order to be awarded attorneys’ fees, plaintiffs must show (1) that the government’s position was not substantially justified, and (2) that plaintiffs are the prevailing party in a civil action against a government official acting in his official capacity. The Secretary conceded his position was not substantially justified, but argued the bad faith hourly rate allowed under the EAJA was not warranted because he did not act in bad faith. The court discussed the “American rule” against the award of attorneys’ fees and the common law exception for bad faith. Bad faith can occur where a party who has a statutory duty fails to perform that duty. The court found clear and convincing evidence that the Secretary acted in bad faith in light of the statutory mandates. Thus, plaintiffs were entitled to attorneys’ fees at the bad faith rates. The court noted that the Secretary’s bad faith arose before litigation and, thus, the plaintiffs were entitled to an award of $173,922 in attorneys’ fees.


_The U.S. District Court for the District of Columbia held that, where the Secretary of HHS failed to comply with statutory mandates, the Secretary was deemed to have acted in bad faith and, thus, plaintiffs were entitled to attorneys’ fees at bad faith rates as allowed by the EAJA._
Federal Circuit Says Award of Attorneys’ Fees Not Available for Appeal of Vaccine Act Claim That Was Dismissed for Lack of Jurisdiction

Parents of a child who suffered an injury from a vaccination filed a claim under the National Childhood Vaccine Injury Act (Act). A Special Master dismissed for lack of jurisdiction because the claim was filed seven months after the statutory deadline. Upon review, the Court of Federal Claims remanded to the Special Master to determine whether the untimely filing might be excused under the doctrine of equitable tolling. When the Special Master determined equitable tolling did not apply and the Federal Claims Court affirmed, plaintiffs appealed. The clerk of the court, however, informed plaintiffs that they could not proceed pro se. Therefore, plaintiffs retained counsel.

The Federal Circuit affirmed the dismissal of plaintiffs’ claim. Because the Act provides for awards of attorneys’ fees for unsuccessful claimants in certain situations, plaintiffs next moved for an award of attorneys’ fees and costs. The Special Master, citing Martin v. Secretary of Dep’t of Health & Human Servs., 62 F.3d 1403 (Fed. Cir. 1995), held that a Special Master who does not have jurisdiction over the merits of a particular claim also does not have jurisdiction over a related request for attorneys’ fees. The appeals court explained that, in Martin, attorneys’ fees could be awarded to unsuccessful claimants that had filed petitions under the Act and were thus “already within the jurisdiction of the court.” The appeals court refused to grant an exception to Martin and refused to award plaintiffs attorneys’ fees. Brice v. Secretary of Health and Human Servs., 358 F.3d 865 (Fed. Cir. 2004).

Claimants under the National Childhood Vaccine Act whose petitions were dismissed for lack of jurisdiction because their claims were filed after the statutory deadline may not be awarded attorneys’ fees as unsuccessful claims because the court does not have jurisdiction.

California Appeals Court Says Plaintiff’s Legal Malpractice Claim was Timely

Plaintiff retained counsel to sue her doctor for medical malpractice, but her attorney (defendant) failed to file the complaint within the statutory limitations period. In discussions regarding resolving this dispute, defendant suggested that plaintiff file a complaint with the California Board of Medical Quality Assurance (BMQA) about the doctor’s malpractice. Despite this ongoing representation, plaintiff sued defendant for legal malpractice. Defendant moved for summary judgment on the ground that the statute of limitations began to run from the discovery of defendant’s failure to timely file the suit.

The California Court of Appeal reversed, finding that the one-year statute of limitations may be tolled by an attorney’s continuous representation of a client for the same “specific subject matter,” despite the argument that the medical malpractice lawsuit
and BMQA complaint constituted two separate matters. The appeals court found that defendant’s failure to file the lawsuit and his drafting of the BMQA complaint arose out of and were connected to the underlying medical malpractice action. Therefore, the appeals court held that the plaintiff’s legal malpractice claim was timely. 


*Plaintiff's legal malpractice claim was timely because of what appellate court found to be continuous representation, thus tolling the statute of limitations.*

**III. MEDICAL RECORDS ISSUES**

**Indiana Appeals Court Finds Social Worker/Client Privilege Statute Was Remedial and Thus Applied Retroactively**

The Pelley family attended counseling sessions at the Family and Children’s Center in Indiana in 1988 and 1989. In April 1989, the Pelley parents and their two daughters were murdered in their home. The State of Indiana charged the Pelleys’ son with four counts of murder and issued a subpoena to the counseling center for its records of the 1988 and 1989 counseling sessions. The center moved to quash the subpoena on the grounds that the social worker/client privilege applied and the communications did not fall within certain exceptions to that privilege. The state argued that the privilege, which became effective in July 1990, should not apply retroactively. In the alternative, the state argued the communications fell within the homicide exception to the privilege.

The Indiana Court of Appeals affirmed, finding that the statutory privilege applied retroactively because it was remedial in nature. The court of appeals addressed the issue of retroactivity, explaining that statutes are not usually applied retroactively unless they are remedial in nature. The court of appeals found no legislative history to indicate the privilege statute was remedial. However, the close temporal proximity of the appeals court’s decision in *Matter of C.P.*, 543 N.E.2d 410 (Ind. Ct. App. 1989), aff’d 563 N.E.2d 1275 (Ind. 1990), and the enactment of the statute made it reasonable to conclude that the statute was intended to be remedial. The appeals court next considered the homicide exception to the social worker/client privilege. The appeals court held the trial court did not abuse its discretion when it conducted an in camera review and determined that the documents did not fall under any exception. **Indiana v. Pelley**, 800 N.E.2d 630 (Ind. Ct. App. 2003).

*Close temporal proximity of an appeals court’s decision to the enactment of a statute made it reasonable to conclude that a statute was intended to be remedial and therefore could be applied retroactively.*
Tenth Circuit Says Designated Patient Protection and Advocacy Systems for Mentally Ill Entitled to Review Hospital Peer Review and Quality Assurance Records

The Center for Legal Advocacy, a designated patient protection and advocacy system for the mentally ill in Colorado, sought declaratory judgment that it was entitled to hospital peer review and quality assurance materials. The 1986 Protection and Advocacy for Mentally Ill Individuals Act (PAMII), 42 U.S.C. § 1081, grants such protection and advocacy systems access to “all records.” PAMII defines “records” as reports prepared by any staff of a facility rendering care or an agency charged with investigation of reports of abuse, neglect, or injury.

The Tenth Circuit held that PAMII records included peer review and quality assurance records. The court refused to accept the lower court’s distinction between patient records and hospital records. In support of its decision, the Tenth Circuit also pointed out that PAMII specifically requires protection and advocacy systems to maintain the same level of confidentiality imposed on mental healthcare providers under state and federal law.

Center for Legal Advocacy v. Hammonds, 323 F.3d 1262 (10th Cir. 2003).

PAMII’s broad grant of access to records means designated patient protection and advocacy systems for the mentally ill have access to peer review and quality assurance records. However, PAMII also requires such systems to maintain the confidentiality of those records.

Massachusetts High Court Rules That Charitable Immunity Defense Remains Valid, Even if Defendant Is Unable to Produce Medical Records Critical to Patient’s Claim

In a medical malpractice action, the defendant, Brigham & Women’s Hospital, Inc., asserted as an affirmative defense Massachusetts’ $20,000 statutory damages cap against charitable corporations. When the defendant was unable to produce relevant medical records, the judge ordered that the defendant be defaulted as to liability and the charitable immunity defense stricken on the grounds that the missing records were critical to proving plaintiff’s claim. The Massachusetts Supreme Judicial Court affirmed the default judgment on liability, but vacated the $4 million damage judgment, reinstating the statutory cap for charitable corporations.


Massachusetts’ statutory damages cap against charitable corporations is mandatory and may not be ignored as a sanction when a defendant is unable (but not unwilling) to produce documents critical to a plaintiff’s claim.

California Appeals Court Finds Incident Reports Privileged Under “Dominant Purpose” Test When Prepared by Self-Insured Hospital for Attorney Review

In a wrongful death suit, plaintiffs served the defendant, Scripps Hospital, with a document discovery request for all reports of incidents during decedent’s hospital stay. The hospital refused to produce five occurrence reports, citing attorney-client
and peer review privileges. The California Court of Appeals overruled the trial court and concluded the reports were privileged because they were for accident prevention and were prepared for attorney review. The appeals court applied the “dominant purpose” test from an earlier case in which incident reports were sent by a hospital to its insurance company in the event of litigation. Scripps, which was self-insured, was able to show that it had produced the reports for its in-house counsel and attorney review.


*Applying the dominant purpose test, occurrence reports produced for attorney review, regardless of whether there was a threat of litigation are privileged, are protected under the attorney-client privilege.*

**New Hampshire Supreme Court Says Trial Court Must Determine if State Adequately Investigated Alternate Source of Information Before Being Granted Access to Privileged Medical Records**

The state issued a subpoena to St. Joseph’s Hospital for the medical records of three individuals injured in an automobile accident. The subpoena was meant to determine if these individuals could be charged with felony aggravated driving while intoxicated based on a “serious bodily injury.” Defendants moved to quash the subpoenas based on physician-patient privilege. The state argued that the records were essential for criminal prosecutions. The trial court agreed with the state enforcing the subpoena finding that there was no alternative way for the state to obtain the information.

The New Hampshire Supreme Court vacated the trial court’s judgment despite the state’s argument that the physician reporting statute is an exception to the physician-patient privilege. The supreme court determined that the state does not have unilateral authority to subpoena medical records when it believes a medical provider might have violated the reporting requirement. Addressing the state’s argument that the medical records were essential, the high court noted that privileged medical records can be disclosed only if the records are unavailable from another source and there is a compelling justification for disclosure. The high court determined that the state’s need to investigate the possibility that a felony was committed constituted a compelling justification. Having shown the compelling justification, the state also had to prove the information was not available from an alternate source. The high court found that the state had failed to show it had adequately pursued alternative information.


*State supreme court remands case back to lower court for determination on whether adequate attempts were made to find alternate source of information other than privileged medical records.*
IV. MEDICAL STAFF ISSUES

Tennessee High Court Says Hospital Had Authority to Enter Into Exclusive Provider Agreement for Imaging Department and to Close Department to Medical Staff

Radiologists who lost their staff privileges to use the imaging department claimed that Cookeville Regional Medical Center (CRMC) retaliated against them for forming Putnam Radiology, PC, and seeking a certificate of need to open a competing outpatient imaging center. The radiologists also claimed that CRMC’s bylaws did not allow the hospital to close the imaging department to the medical staff. The trial court granted summary judgment to CRMC based on Tennessee’s Private Act Hospital Authority Act, which allows the closing of a department for competitive reasons. The appeals court affirmed.

The Tennessee Supreme Court affirmed the judgment on three grounds. First, the supreme court found that private act hospitals, as with metropolitan hospitals, may enter into exclusive provider agreements regardless of competitive effect. Second, the hospital bylaws clearly state that the medical staff’s input into decisions is purely advisory and that the hospital’s board of trustees retains final decision-making authority. Finally, the supreme court held that the complaint brought by the radiologists did not fit the type of actions for which the bylaws provide a hearing. Additionally, while the supreme court agreed that the hospital was a state actor, the court found that the hospital’s failure to provide the radiologists a hearing regarding their privilege termination did not violate the radiologists’ due process rights because they had no reasonable expectation of a right to notice and a hearing for a strictly business decision. Therefore, there was no protectable property interest in the loss of their privileges by the closing of the imaging department.

City of Cookeville v. Humphrey, 126 S.W.3d 897 (Tenn. 2004).

A Tennessee private act hospital’s entering into an exclusive agreement for operation of its imaging department and the closing of its imaging department to medical staff did not violate the medical staff’s contractual rights under hospital bylaws or their due process rights.

V. MEDICARE PROVIDER ISSUES

U.S. Court in Ohio Says Resident Hours Need Not Be Related to Direct Patient Care to Be Counted in FTE Residency Count

The fiscal intermediary (FI) of Riverside Methodist Hospital downwardly adjusted the Hospital’s full-time equivalent (FTE) residency count to reflect activities related to hands-on patient care. The Provider Reimbursement Review Board (PRRB) reversed the FI’s determination. When the CMS administrator reversed the PRRB’s decision, the hospital appealed. The U.S. District Court for the Southern District of Ohio ruled that resident hours do not need to be spent performing activities directly related to hands-on patient care in order to be counted in the calculation of a teaching hospital’s
indirect medical education (IME) cost adjustment under Medicare. Specifically, the
court ruled that hours spent by residents in Journal Club, Practice Management
Seminars, OB/GYN Seminars and Psychiatry Seminars constituted patient care within
the plain language of a governing regulation at issue, 42 C.F.R. § 412.105(g). As
noted by the court, the regulation does not contain nor imply any requirement that only
hours spent providing actual care can be included for purposes of the resident count.
Rather, the regulation contains only two requirements: (1) that the resident is enrolled
in an approved teaching program, and (2) that the resident is assigned to a portion of
the hospital subject to the PPS or the hospital’s outpatient department. According to
the court, because indirect costs cannot be adequately itemized and quantified,
Congress devised a formula as a substitute for reimbursing such costs.
**Riverside Methodist Hospital v. Thompson**, No. C2-02-94 (S.D. Ohio July 31,
2003).

*Regulations governing IME adjustment do not contain nor imply any requirement that
only resident hours spent providing actual patient care can be included for purposes of
the resident count.*

**D.C. Circuit Says DHHS Secretary’s Adjustment to OPPS Pass-Through Rates
for New Treatment Was Not Subject to Judicial Review**

After the FDA approved Amgen’s biological product Aranesp, CMS informed Amgen
that it was including Aranesp in the outpatient prospective payment system (OPPS)
reimbursement rates. In its proposed 2003 OPPS rates, CMS included supplemental
pass-through payments for Aranesp. The manufacturer of Procrit, a competitor
product that is not eligible for pass-through payments, submitted comments
questioning the pass-through payments in light of the similarity of the two products.
The 2003 OPPS Final Rule eliminated the pass-through payments for Aranesp, which
CMS determined to be functionally equivalent to Procrit. Amgen sued DHHS and the
CMS Administrator, claiming that elimination of the pass-through payment violated the
Medicare Act. The D.C. Circuit affirmed the trial court’s dismissal of the case.

The D.C. Circuit explained that, under the Administrative Procedure Act (APA), a
plaintiff must prove that an alleged injury within the “zone of interest” protected by the
statute upon which the complaint is based. The appeals court noted the purpose of the
Medicare Act is to make new treatments available found that Amgen’s financial
interests were sufficiently related to the interests of Medicare beneficiaries obtaining
access to new treatments to warrant Amgen’s prudential standing. The appeals court
next considered whether jurisdiction existed. The Medicare Act provides there is no
administrative or judicial review of “other adjustments” to the OPPS. The appeals
court stated that while there is a strong presumption that Congress intends judicial
review absent evidence rebutting that presumption, the Secretary’s authority under 42
U.S.C. § 13951(t)(2)(E) permits him to make adjustments “necessary to ensure
equitable payments.” The appeals court concluded the downward adjustment for
Aranesp reimbursement fell within the Secretary’s authority and therefore affirmed the
district court’s dismissal of Amgen’s lawsuit.
**Amgen, Inc. v. Smith**, 357 F.3d 103 (D.C. Cir. 2004).
Congress delegated authority to the Secretary (through CMS) to determine OPPS rates and make adjustments to them. Therefore, the district court did not have jurisdiction to consider a complaint against the Secretary for his downward adjustment to the OPPS rate.

Fifth Circuit Says CMS Correctly Determined That Healthcare Provider Was Not Entitled to Earlier Medicare Certification Date Because Provider Had Withdrawn from Certification Process
In its initial certification survey by the Texas Department of Health (TDH) in 1999, Big Bend Hospital Corporation (Big Bend) was found to be out of compliance with Medicare regulations. On October 27, TDH completed another survey and found Big Bend to be in compliance. Thus, TDH recommended Medicare certification. Shortly thereafter, CMS sent its own surveyors for an unannounced survey. During the CMS survey, Big Bend was again found to be out of compliance. Big Bend requested that the CMS survey be stopped, and by letter dated December 7, 1999, Big Bend notified CMS it was withdrawing from the Medicare certification process. In January 2000, Big Bend requested a new survey. On February 3, 2000, TDH and CMS resurveyed Big Bend, and CMS certified Big Bend for Medicare participation effective that day. Big Bend requested that certification be effective retroactively to October 27. CMS denied the request for reconsideration and, after a number of appeals, the Fifth Circuit affirmed. As support for its decision to deny making Medicare certification retroactive to October 27, 1999, the Fifth Circuit cited the administrative law judge's determination that Big Bend had formally withdrawn from the Medicare certification process in December 1999.


A hospital abandons its claims to an earlier Medicare certification effective date when it formally withdraws from the Medicare certification process.

VI. MEDICAID PROVIDER ISSUES

California Appeals Court Finds No Administrative Finality in Historical Costs Associated with Previous Depreciation Reimbursement of Assets Under Medi-Cal
Medi-Cal allows providers to seek annual reimbursement for depreciation on buildings and equipment used to provide services to Medi-Cal patients. Redding Medical Center (Redding) claimed such depreciation in its FY 1996 and 1997 cost reports. During an audit by the Department of Health Services (DHS), Redding submitted a “lapsing schedule” showing changes it had made to certain historical costs of assets on which it claimed continuing depreciation. DHS then requested that Redding document the assets’ reported historical costs. Redding claimed those historical costs had appeared in previous cost reports that were final under Cal. Wel. & Inst. Code § 14170, which deems a cost report true and correct after three years. Redding argued those previously documented historical costs were applicable to all future cost reports.
However, DHS disagreed and disallowed depreciation reimbursement for certain assets in FYs 1996 and 1997 due to inadequate documentation.

The California Court of Appeal, Third Appellate District, affirmed the lower court holding that DHS could require Redding to document historical costs of depreciation. Relying on the statute’s plain language and case law, the appeals court concluded that, where DHS had not audited a cost report within the three-year period, the data is deemed true and correct for that cost report only, but not for future cost reports. The appeals court explained “fixed” historical costs based on past cost reports is contrary to the notion that betterments and improvements can change historical costs. As additional support for its conclusion, the court pointed to Redding’s lapsing schedule that also evidences the fact that historical costs cannot be “fixed” based on past cost reports or audits.


Although data contained in a cost report is deemed true and correct for that cost report three years after submission, DHS should not be foreclosed from verifying a current claim, including the historical cost underlying it, for future cost reports.

VII. PAYMENT ISSUES

Ninth Circuit Says Claims “Inextricably Intertwined” with Medicare Benefits Determinations Require Exhaustion of Administrative Remedies Even for Constitutional Claims

Without first exhausting the administrative process, the owners of a bankrupt home health agency pursued constitutional and statutory claims against the fiscal intermediary and the federal government. The district court granted defendant’s motion to dismiss, holding that, because plaintiffs’ claims “arose under” Medicare, plaintiffs were required to first exhaust administrative review.

The Ninth Circuit affirmed the finding that plaintiffs’ claims “arose under” Medicare because they were “inextricably intertwined” with a Medicare benefits determination. The court rejected plaintiffs’ argument that their claims did not arise under Medicare because the damages sought were not available through the administrative process. The appeals court stated, “simply put, the type of remedy sought is not strongly probative of whether a claim falls under [42 U.S.C.] § 405 (h).” Further, the appeals court held that plaintiffs did not meet the conditions for a waiver of the exhaustion requirement under § 405 (g) because “past injury does not meet the irreparability requirement of waiver.”

Kaiser v. Blue Cross of Cal., 347 F.3d 1107 (9th Cir. 2003).

Claims that are inextricably intertwined with Medicare benefits determinations arose under Medicare, thus requiring plaintiffs to exhaust administrative review prior to pursuing constitutional and statutory claims.
Tenth Circuit Says Exhaustion of Administrative Remedies Is Not Required if Action Challenges Validity of Secretary's Instructions and Regulations

Following the invalidation of the May, 1986, Disproportionate Share Hospital (DSH) adjustment regulations, the Secretary of Health and Human Services issued Ruling 97-2, detailing a new DSH calculation that would be applied prospectively to only those providers that had appeals pending regarding the Notice of Program Reimbursement (NPR). Plaintiffs had not utilized the NPR appeals period but timely requested that their fiscal intermediaries (FIs) reopen the NPRs for the years at issue. The FIs refused to reopen the NPRs, and plaintiffs filed suit. The district court, finding jurisdiction under the mandamus statute, held plaintiffs could have certain of their NPRs reopened to recalculate DSH adjustments.

The Tenth Circuit found that mandamus jurisdiction did not apply because plaintiffs had not exhausted all other remedies, and the Secretary did not owe any duty to plaintiffs. However, the appeals court noted a narrow exception to the general rule barring federal question jurisdiction for Medicare-related claims exists for “challenges to the validity of the Secretary’s instructions and regulations.” Here, rather than challenging actual benefits calculations, plaintiffs challenged the validity of Ruling 97-2, which would not allow reopening of cost reports. Because there were no procedures under which plaintiffs could receive a review, federal question jurisdiction was warranted. Turning to the merits of the case, the Tenth Circuit held plaintiffs had failed to state a claim upon which relief could be granted and remanded the case on the ground the Secretary was entitled to summary judgment on all claims. *Bartlett Mem’l Med. Ctr., Inc. v. Thompson*, 347 F.3d 828 (10th Cir. Oct. 20, 2003).

*Despite the absolute bar to federal question jurisdiction for Medicare-related claims, federal question jurisdiction is warranted in narrow circumstances in which plaintiffs challenge the validity of the Secretary’s instructions or regulations, rather than benefits calculations.*

Third Circuit Holds That Recovery of Medicare Payments from Settlement of Product Liability Claim “Arises Under” Medicare Act and Requires Exhaustion of Remedies

As part of the class action settlement of product liability claims related to orthopedic bone screws manufactured by AcroMed, AcroMed placed $100 million into a trust fund for distribution to qualifying class members. Thereafter, the government announced that it planned to recover amounts Medicare had paid for class members’ medical care in connection with the faulty bone screws, citing the Medicare Secondary Payer (MSP) statute.

The Third Circuit held that a claim seeking to enjoin the government’s recovery attempts “arose under” the Medicare Act and therefore precluded federal question jurisdiction. According to the Third Circuit, the Medicare Act provides both the standing and substantive basis for the class members’ claim because the dispositive issue was whether AcroMed is a “self-insured plan” within the meaning of the MSP statute. Citing U.S. Supreme Court precedent, the Third Circuit determined that “the
class members must proceed through the special review channel that the Medicare statutes create,” and, thus, the district court lacked subject matter jurisdiction. **Fanning v. United States**, 346 F.3d 386 (3rd Cir. 2003).

*Where the Medicare Act provides both the standing and the substantive basis for the parties’ contentions, the claim “arises under” the Act, and the remedies provided by the Act apply.*

**California Appeals Court Says Constitutional Prohibition Against Unfunded Mandates Permits Recovery of Cost of Care for Medically Indigent Adults**

After San Diego County exhausted its state allocation of the Medically Indigent Services Account, the state declined to provide additional funding, and the program was discontinued. The county sued the state, arguing that, by terminating the medically indigent adults program from Medi-Cal and transferring responsibility to the counties, the state had violated the state constitution, which prohibits unfunded state mandates. The trial court issued a pre-emptory writ of mandate, and the state appealed. The appeals court affirmed the trial court’s decision that California’s constitution required the state to fund the CMS program, but reversed the determination of the amount to be reimbursed. On appeal, the high court held the legislature intended that counties assume responsibility for medically indigent adults, but did not impose minimum funding requirements. Therefore, the court remanded the case to the Commission on State Mandates. An administrative law judge (ALJ) recommended that the commission dismiss the county’s claims, finding that the county’s contracts with providers placed healthcare providers at risk in the event there was a shortfall in state funding. The commission adopted the ALJ’s recommendation, and the trial court agreed.

The California Court of Appeal reversed, finding the providers had not accepted the risk of a shortfall in state funding. The appeals court also determined the commission had not rejected the county’s claim based on a lack of evidence, but rather, upon risk shifting and co-mingling with CHIP funds. Therefore, the commission’s alternative argument that the county failed to provide sufficient evidence was unsupported. However, the appeals court agreed the state was entitled to credit for CHIP funds, which were used for the CMS program. Accordingly, the appeals court concluded the county had spent more than $3 million in excess of what the state provided and was entitled to that amount for the unfunded mandate. **County of San Diego v. Commission on State Mandates**, No. D039471, 2003 WL 22205626 (Cal. Ct. App. Sept. 24, 2003).

*The state of California was required to reimburse the county for expenses it incurred providing healthcare services to medically indigent adults as required by a state law that contravened the state’s prohibition on unfunded mandates.*
U.S. Court in District of Columbia Says Secretary’s Decision Not to Retroactively Adjust Long Term Acute Care Hospital’s Reimbursement on Reasonable Cost Basis Was Permissible Under Medicare Statute

A group of affiliated Select Specialty long term acute care hospitals (plaintiffs) filed an action arguing that Medicare reimbursements fell short by a collective $1.5 million because they were improperly paid under the prospective payment system (PPS) for inpatient operating costs in their first cost reporting period instead of on the basis of their reasonable costs. Plaintiffs had filed a Provider Reimbursement Review Board (Board) appeal regarding their fiscal year 1998, seeking reimbursement of their reasonable costs, instead of PPS, during this period. The Board granted plaintiffs’ request for expedited judicial review, and plaintiffs filed suit in federal district court, alleging that the Secretary’s interpretation was contrary to the intent underlying the PPS and results in systematic underpayment to long term care hospitals in their first cost reporting period.

The U.S. District Court for the District of Columbia upheld the Secretary’s interpretation of the regulations. The court rejected plaintiffs’ argument that the congressional intent underlying the PPS exclusions required the Secretary to adopt self-certification or retroactive adjustments to reimbursements. According to the court, “congressional intent behind the PPS exclusion does not speak to how the Secretary must take into account the inpatient services hospitals will provide to these types of patients. Furthermore, determining whether a hospital fits a PPS exclusion is entwined with implementation of the PPS system.” Thus, the court concluded that the Secretary’s decision was permissible under the Medicare statute.


There is no self-certification or retroactive adjustment for long term acute care hospitals to support exclusion from PPS during their start-up period. Exclusions will apply only to the subsequent period.

Kansas Supreme Court Holds Hospitals May Not Offset Written-Off Medical Expenses Pursuant to Medicare Against Damages Judgment in Beneficiary’s Negligence Action

Lyle Rose, a Medicare beneficiary, was admitted to a hospital owned by Via Christi Health System (Via Christi) for a cardiac procedure. While in the hospital, but before surgery, Rose fell out of bed, sustained a head injury, and died. Via Christi billed Medicare for the full cost of Rose’s treatment related to the fall. Medicare paid Via Christi $87,911.60, requiring the hospital to write off $154,193.24 of the total $242,104.84 that it billed. Rose’s wife and estate (plaintiffs) sued Via Christi for negligence in the state trial court. First, the court denied Via Christi’s motion in limine to limit evidence of medical expenses to the amount actually paid by Medicare, pursuant to the collateral source rule. A jury found Via Christi 36% at fault, and the trial court granted Via Christi’s motion to offset the judgment by the written-off medical expenses. Plaintiffs appealed.
The Kansas Supreme Court reversed the trial court’s decision to allow Via Christi to offset the judgment by the written-off medical expenses. The court agreed, however, with the trial court’s refusal to limit the evidence of medical expenses to those amounts actually paid. The court held that the collateral source rule applies to Medicare write-offs. The court stated, “because health care providers voluntarily contract with Medicare in the same manner as they contract with other private insurers for reduced rates, the benefit of the write-offs should be attributed to the Medicare participant rather than the health care provider.” Moreover, public policy in Kansas supports the theory that any windfall from the injured party’s collateral sources should flow to the injured party rather than the tortfeasor. Thus, the court held that the trial court did not err in its judgment on this issue.


A hospital may not offset medical expenses it wrote off pursuant to Medicare’s payment against a damages judgment in a negligence action.

Second Circuit Rules That Plaintiff’s MSPA Action Was Barred by Previous State Court COBRA Action

Plaintiff sued Metropolitan Life Insurance Company, United Healthcare Services Corporation, and the New York State Department of Civil Service (collectively “defendants”) under the Medicare Secondary Payer Act (Act), alleging that defendants had failed to inform him when he left his employment with the state that he needed to enroll in Medicare as his primary healthcare payer. The federal district court granted defendants’ motion to dismiss the action as barred under the doctrine of res judicata, stating that plaintiff had initially sued defendants in state trial court, claiming failure to notify him about enrolling in Medicare after his employment ended violated the Consolidated Omnibus Budget Reconciliation Act (COBRA) and seeking payment of all of his medical expenses.

The Second Circuit affirmed, applying New York’s “transactional approach” to resolve the res judicata issue and finding that all of plaintiff’s claims arose from the same series of transactions. The appeals court rejected plaintiff’s argument that the COBRA and MSPA claims involved contradictory factual assertions and that, because COBRA remedies are limited to “appropriate equitable relief,” federal law prevented him from asserting claims for damages under the MSPA. The appeals court noted that neither COBRA’s equitable provisions nor state law prevented him from simultaneously pursuing remedies for claims brought under other statutes whether in state or federal court.


Plaintiff’s MSP claim in federal court is barred by res judicata when a COBRA claim regarding the same factual situation was previously filed in state court.
Seventh Circuit Says State Must Provide Long Term Residential Psychiatric Treatment Facilities for Children

Indiana is required by Medicaid to provide treatment to anyone who is found, as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, to need treatment for mental illness. Indiana’s Medicaid plan only covers outpatient treatment of a child diagnosed with a mental illness, and does not cover residential placement of a child in a psychiatric residential treatment facility (PRTF). Plaintiffs, both children with mental illnesses, filed a class action against various Indiana officials for failing to provide treatment in PRTFs to children, seeking declaratory and injunctive relief that Indiana had to provide residential treatment if a child was found to have a mental illness for which “medically necessary” treatment was needed under the EPSDT program. The district court held that Indiana’s Medicaid program must cover residential mental illness treatment for eligible children if the screening finds treatment is “medically necessary.”

The Seventh Circuit affirmed. The appeals court addressed whether Indiana had the discretion under Medicaid to exclude residential treatment of chronic mental illness in children. The appeals court looked to the Medicaid statute and regulations, which specifically include PRTFs within the meaning of “inpatient psychiatric hospital” and “therefore placement in a PRTF is included within the ambit of covered EPSDT services.” In its argument Indiana mistakenly assumed long term care in a residential facility equated to perpetual responsibility. The appeals court held that a PRTF is an inpatient psychiatric hospital for purposes of Medicaid, and Medicaid must cover a placement of a mentally ill child in a PRTF that is a result of an EPSDT screening. Collins v. Hamilton, 349 F.3d 371 (7th Cir. 2003).

Mentally ill children’s stay in long term residential psychiatric treatment facilities are covered by Medicaid according to the Seventh Circuit.

U.S. Court in Illinois Says Nursing Home that Required Personal Guarantee from Family Member as Condition to Admitting Resident Violated Medicaid Act

When John R. McDonald was admitted to Meadowbrook Manor Bolingbrook, the nursing home told McDonald’s son-in-law, David P. Carroll, that he had to sign a personal guarantee holding him liable for any pre-arranged fees that McDonald was unable to pay. When Meadowbrook garnished Carroll’s wages, Carroll sued Meadowbrook, alleging that the personal guarantee violated the Medicaid Act and violated the Illinois Consumer Fraud Act (CFA).

The U.S. District Court for the Northern District of Illinois found that Meadowbrook had violated the Medicaid Act and denied Meadowbrook’s motion to dismiss. Under 42 U.S.C. §1396r(c)(5)(A)(ii), a nursing home is prohibited from requiring “a third party guarantee of payment to the facility as a condition of admission . . . to or continued stay in, the facility.” The court did dismiss the CFA claim, holding that the nursing home’s conduct did not offend public policy and that Carroll had failed to allege a substantial injury.

Personal guarantees as a condition of admission to a nursing home violate the Medicaid Act.

Sixth Circuit Rules Acute Care Hospital That Purchases SNF Beds Is “New Provider” of SNF Services for Purposes of Relief from RCLs

In 1995, Ashtabula County Medical Center (ACMC) purchased fifteen nursing home beds from Ashtabula County Home (ACH). ACMC was granted a certificate of need allowing it to relocate those beds to its premises. In March 1996, ACMC became Medicare-certified as a skilled nursing facility (SNF). That same year, ACMC requested a new provider exemption from the routine cost limits (RCLs). Under the exemption, a “new provider” is defined as “a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than 3 full years.” 42 C.F.R. § 413.30(e). ACMC brought the current suit in federal district court after HCFA denied its request and the PRRB affirmed. The Sixth Circuit framed the issue as being whether ACMC, by acquiring fifteen beds from a distinct entity, was a new provider for purposes of the exemption, or whether the arrangement was merely a change of ownership of an institution existing for over three years. Despite § 413.30(e)’s failure to define the term “provider,” the appeals court found its meaning clear by reference to related statutes. The appeals court found the term “provider” as unambiguously referring to an institution or distinct part of an institution, rather than a mere characteristic or attribute of such institution. Accordingly, the appeals court determined that ACMC’s new SNF did not exist until it purchased ACH’s certificate of need. Therefore, ACMC qualified as a new provider for purposes of the exemption from the RCLs. Ashtabula County Med. Ctr. v. Thompson, 352 F.3d 1090 (6th Cir. 2003).

A hospital that purchased nursing home beds so that it could operate a SNF on its premises was entitled to the new provider exemption from routine cost limits.

U.S. Court in Massachusetts Says Exhaustion of Remedies Under Medicare Act Applies to U.S. Government

Based upon a national investigation by the Department of Justice (DOJ) into Medicare billing, the DOJ sued the University of Massachusetts Memorial Medical Center to recoup alleged overpayments for outpatient services. Defendant moved to dismiss or, in the alternative, for judgment on grounds that the court lacked subject matter jurisdiction because the government had failed to exhaust its administrative remedies. In a question of first impression, the U.S. District Court for the District of Massachusetts considered whether the jurisdictional limits of 42 U.S.C. § 405(h) apply to actions brought by the United States. The court based its interpretation of § 405(h) on the second sentence of that section, which requires administrative exhaustion.
With regard to the third sentence, which refers to actions brought against the United States, the court stated that taking that sentence out of context and interpreting it separately ignores the plain language of the section as a whole. Therefore, the court held the government is required to exhaust its administrative remedies before pursuing other means and, thus dismissal was appropriate. **United States v. University of Mass. Mem’l Med. Ctr.,** 296 F. Supp. 2d 20 (D. Mass. 2003).

*The United States government is required to exhaust administrative remedies before bringing suit to recover alleged Medicare overpayments.*

**Seventh Circuit Holds That Remand for Further Information Is Not Appealable Final Judgment**

In 1989, Edgewater Hospital sold its building, equipment, records, and ongoing operations to Edgewater Operating Co. Edgewater Hospital then changed its name to Edgewater Foundation. On the date of sale, the buyer and seller agreed that Medicare owed the hospital $6.4 million, and the buyer (Edgewater Operating Co.) owed Medicare $4 million in overpayments for 1989 and 1990. After calculating the offset, Medicare paid the balance of $2.4 million. The Foundation, however, claimed it was entitled to interest on the $6.4 million between the sale in January 1989 and the time the offset payment was received. Specifically, the Foundation claimed the overpayments that were made after it sold the hospital should not be offset against underpayments that occurred before the sale. An administrative proceeding was held by the HCFA (now CMS) Administrator, who determined that Medicare was entitled to treat the hospital as a single provider regardless of the arrangements between the Foundation and the Operating Co. The Foundation sued, and the district court remanded the matter for the Department of Health and Human Services to make certain determinations. The Foundation appealed to the Seventh Circuit.

The Seventh Circuit dismissed the suit for lack of jurisdiction, explaining that judicial review of the Administrator’s decision must first be in district court. The Foundation, citing U.S. Supreme Court precedent, argued that remand to an agency is appealable. The Seventh Circuit disagreed, stating the rule that could be drawn from the cases relied upon by the Foundation was that, if a court delays a final adjudication based on a remand for additional information, there has been no final decision. Accordingly, the decision was not appealable. **Edgewater Foundation v. Thompson,** 350 F.3d 694 (7th Cir. 2003).

*When a court delays a final adjudication based upon a remand for additional information, there has been no final decision, and the remand is not appealable.*

**Arizona Appeals Court Says State Has Power to Compromise Only State, not Federal, Portion of Right of Recovery for Medicaid Payments**

Plaintiff, an Arizona resident and Medicaid recipient, sued several manufacturers of hemophilia products from which he contracted HIV. Following a trial in which a verdict was rendered for the manufacturers, plaintiff and the manufacturers began settlement
negotiations. The Arizona Health Care Cost Containment System (AHCCCS) contracted with the Public Consulting Group (PCG) to have an employee attend the settlement conferences. As part of the settlement conference, plaintiff asked about a Medicaid lien of $17,645.05, and the PCG employee suggested that plaintiff accept the settlement offer and then seek to have the lien administratively reduced. Plaintiff then settled for $50,000, and AHCCCS agreed to compromise the state share of the lien, leaving the federal portion of more than $11,000. Plaintiff filed an administrative challenge to AHCCCS’ refusal to compromise the entire lien. An administrative law judge (ALJ) held the federal portion of the lien could not be compromised by the state and that the PCG employee had misrepresented the issue to plaintiff. Nonetheless, that misrepresentation did not estop AHCCCS from refusing to compromise the federal portion of the lien. On appeal, the superior court affirmed the ALJ’s decision.

On appeal to the Arizona Court of Appeals, plaintiff argued that AHCCCS was liable for the PCG employee’s misrepresentations, which he claimed were fraudulent. Plaintiff’s fraud claim was rejected because he only brought a claim challenging the denial of his request for a compromise of the lien and failed to support his fraud claim with any authority. Citing administrative decisions by DHHS and case law from New York and New Jersey as precedent, the appeals court held that CMS’ interpretation of federal Medicaid requirements is dispositive, and states are bound by their duty to repay the Medicaid program even if the state believes the entire lien should be compromised. Accordingly, AHCCCS did not err in declining to waive the federal Medicaid amount and its decision was neither arbitrary nor capricious. Eaton v. Arizona Health Care Cost Containment Sys., 79 P.3d 1044 (Ariz. Ct. App. 2003).

*Medicaid liens may be compromised to facilitate settlement, however, if there are sufficient funds available, the federal Medicaid portion must be reimbursed, even if the state compromises its portion.*

**North Carolina Appeals Court Says Medicaid Coverage for Undocumented Aliens Applies Only as Long as Alien Suffers “Emergency Medical Condition”**

An undocumented alien presented at the emergency room of Moses Cone Hospital in North Carolina on December 26, 1999, where he was diagnosed with thoracic myelopathy and a malignant spinal cord neoplasm. Following surgery and resection of the tumor, plaintiff was transferred to the hospital’s rehabilitation unit. On January 14, plaintiff was transferred to the oncology unit and began receiving chemotherapy until the date of his release, January 24, 2000. In April 2000, plaintiff applied for and received Medicaid benefits covering his initial treatment from December 26, 1999 through January 3, 2000. However, coverage was denied for treatment after that date because plaintiff did not have an emergency medical condition. Plaintiff filed for judicial review after the State Department of Health and Human Services affirmed the decision.

The North Carolina Court of Appeals vacated and remanded the trial court’s decision, stating that Medicaid regulations do not provide coverage for undocumented aliens
unless the alien is suffering from an emergency medical condition. Because neither party had addressed whether plaintiff had a chronic or emergency medical condition, the court of appeals remanded for findings of medical fact on this issue.


Medicaid provides coverage for undocumented aliens suffering from emergency medical conditions, but such coverage ends when the patient's condition is no longer an emergency.

Texas Appeals Court Holds That Medicaid Fast-Track Termination Procedures Apply to ICF/MR Facilities

The Texas Department of Human Services conducted a survey of Fleetwood Community Home, an ICF/MR for Medicaid participation. The Department determined there was a serious threat to the health and safety of the facility’s residents, which warranted termination of Fleetwood’s Medicaid certification. Prior to the termination date, Fleetwood notified the Department that it had corrected the deficiencies. However, upon resurvey, the Department found additional violations, and termination resulted. An administrative law judge recommended the termination be affirmed, and the Department denied Fleetwood’s request for rehearing. Fleetwood appealed, arguing fast-track termination applied and any deficiencies had been remedied on the twenty-third day following the survey. The Department argued that fast-track termination applied only to nursing facilities and not ICF/MRs. An analysis by the Texas Court of Appeals indicated that ICF/MRs are covered by the fast track procedure. The appeals court next looked to whether the Department’s decision was arbitrary or capricious, or was supported by substantial evidence. The appeals court found the Department had provided sufficient evidence to support its finding that Fleetwood had not remedied the deficiencies at the time of resurvey. Further, the Department had not abused its discretion by omitting facts that the statute intended to be considered. Accordingly, the appeals court affirmed the lower court’s judgment terminating Fleetwood’s Medicaid certification for ten days.


Fast-track termination applies to ICF/MRs. Department/Agency termination decisions may be supported by substantial evidence and not arbitrary or capricious even if some factors mentioned in law or regulation are overlooked in reaching the decision.

U.S. Court in Colorado Says States Retain Flexibility to Offer or Terminate Optional Medicaid Coverage Under Personal Responsibility and Work Opportunity Reconciliation Act

A Colorado law repealed the state’s optional coverage of certain qualified legal immigrants in the Medicaid program. Plaintiffs sued, claiming more than 3,000 Medicaid recipients would have their benefits terminated in direct violation of the Due Process and Equal Protection Clauses of the Fourteenth Amendment and federal Medicaid law. The U.S. District Court for the District of Colorado denied plaintiffs’ motion for a preliminary injunction and dissolved the temporary restraining order, citing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,
which implemented classifications for legal immigrants, leaving little discretion to the states. Further, there was a rational basis for the treatment of excluded recipients and the state’s need to make budget cuts. Accordingly, plaintiffs’ motion for preliminary injunction was denied.


*Federal law mandates services to certain categories of individuals while giving each state the option of providing services for other (optional) categorically needy individuals. Individuals could not enjoin a state from exercising this option.*

**CMS Publishes Final Rule Revising Methodology for Determining Outlier Payments for Hospitals**

CMS is reducing reimbursements to hospitals for expensive Medicare patients. Fiscal year 2004 brings a lower threshold for these high-cost “outlier” payments. Features of the June 9, 2003, final rule include:

- guidance on computing high cost and short stay outlier payments;
- a plan to give intermediaries instructions on identifying hospitals receiving too much outlier payment;
- authorization for these intermediaries to review and adjust payments;
- authorization for hospitals to request cost-to-charge ratio changes from intermediaries;
- requirements to use the latest cost report in calculating cost-to-charge ratio, starting October 1, 2003;
- the end of using state average cost-to-charge ratios to name the cost of hospitals with below-average cost-to-charge ratios.

**Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems**, 68 Fed. Reg. 34493 (Dep’t Health and Human Servs., Ctrs. for Medicare & Medicaid Servs., Final Rule June 9, 2003).

*The final rule addresses concerns of hospitals with low costs while capping excessive Medicare bills.*

**U.S. Court in North Carolina Says Secretary Improperly Excluded Hospital’s Swing-Bed Days in DSH Eligibility Calculation**

Under HCFA (now CMS) approval, plaintiff District Memorial Hospital of Southwestern North Carolina used some of its acute-care beds to provide temporary skilled nursing care from 1991-1997. While many of these nursing patients were low-income, plaintiff’s fiscal intermediary refused to count their days. Thus plaintiff was ineligible for Medicare funds for its disproportionate share of low-income patients.

The U.S. District Court for the Western District of Carolina granted plaintiff summary judgment. The court held that the CMS Secretary improperly excluded the swing bed patient days from the disproportionate share eligibility calculation for fiscal years 1991-1997. The Secretary cited 42 C.F.R. § 412.106, arguing that “patient days” are only
“days attributable to areas of the hospital that are subject to the prospective payment system” and “areas” is intended to mean services covered under prospective payment. The court countered that the ordinary meaning of “area” is “a geographic region of the hospital”; the patients were treated within an acute care hospital and thus form part of the calculation.


Disproportionate share funds are not received easily. Still, whatever CMS’s intent, the plain interpretation of language matters.

ALJ Finds Medicare Carrier’s Overpayment Determination Based On Statistical Sampling Invalid
Podiatrist Michael Gavigan, MD, appealed an overpayment determination from Medicare carrier National Heritage Insurance Company. The carrier claimed that Gavigan had been overpaid for services rendered in 1998 and 1999. Gavigan argued that the statistical methodology used to calculate the refund was invalid.

An administrative law judge found in favor of Gavigan. The carrier did not document its sampling process or relative error rate, and relied on a sample 25% of the recommended size. Thus, the overpayment determination was based on invalid statistical extrapolation.

In re Gavigan, No. 999-09-4291 (Soc. Sec. Admin. Office of Hearings and Appeals).

The government’s interest in statistical sampling for convenience can be outweighed by the interest of the provider.

U.S. Supreme Court Says Injunction Blocking Maine Rx Program Was Not Warranted
Pharmaceutical Research and Manufacturers of America filed suit, claiming that the Maine Rx Program violated the Commerce Clause and was pre-empted by the Medicaid Act. Maine intends to use bulk purchasing power to negotiate rebates from drug manufacturers, then reimburse pharmacies that sell discounted drugs.

The U.S. Supreme Court rejected the Commerce Clause challenge because Maine would not regulate the price of out-of-state transactions or impose a disparate burden on competitors. The Court also rejected the district court’s argument that the Medicaid Act pre-empted such a program. Justices found three Medicaid-related goals of the Maine Rx Program: it benefits the “medically needy,” it could reduce Medicaid expenses, and it could produce savings for high-volume purchasers.


If the Maine program is shown to compromise federal interests or have no Medicaid-related goal, this and similar state prescription drug programs may be subject to challenge.
Louisiana Appeals Court Affirms Judgment Against Accounting Firm for Failing to Obtain Maximum DSH for Hospital Client
Plaintiffs Drs. Jackie Huckabay and Fred Willis, owners of L.S. Huckabay MD Memorial Hospital, sued auditors, KPMG Peat Marwick LLP, for failing to recover maximum disproportionate share reimbursement. A potential purchaser reviewed the KPMG cost reports, and claimed to find approximately $1.5 million additional DSH reimbursement. KPMG argued that the hospital had constructive knowledge of the cause of action when it contracted the cost report review. KPMG also claimed the trial court could not find KPMG negligent, because it was operating within the standard of care. The Louisiana Court of Appeals, Second Circuit, affirmed the trial court’s judgment, finding KPMG liable for breach of contract under the theory that the hospital had contracted with KPMG to seek the maximum DSH and because KPMG failed to do so it breached its contract. The appeals court awarded the hospital $439,712 for cost report review fees.

Hospitals may successfully hold their auditors accountable for failing to prepare cost reports in a manner that produces the highest reimbursement permitted under the law.

Missouri Appeals Court Reverses Declaratory Judgment That Regulations on Review of Psychiatric Hospital Admissions Were Invalid and Says Regulations Were Not Arbitrary or Capricious
The Missouri Department of Social Services (DSS) ordered Psychiatric Healthcare Corp. of Missouri to pay back $92,445 in Medicaid payments, citing two DSS regulations governing the certificate of need reviews of treatment records. The trial court had held that the regulation allowing physician reviews to deny hospitalization without written standards violated due process and that the regulation imposing penalties for late or improper CON forms was too harsh and therefore was invalid.

The Missouri Court of Appeals, Western District, reversed the trial court’s judgment, upholding the regulations and ordering the hospital to pay back Medicaid for all but one of the patients in question.

Physician review of medical necessity that incorporates procedural safeguards may save a regulation from being deemed arbitrary and capricious. Harsh penalties designed to ensure compliance with regulations bear a rational relationship to legitimate goals.

Michigan Appeals Court Says Physician Avoids Joint and Several Liability for Medicaid Overpayment
Plaintiff, an employee of Psychological Services of Michigan (PSM), completed a Michigan Department of Community Health (MDCH) Medical Assistance Enrollment Agreement, which allowed PSM to use plaintiff’s provider number and receive payment for services rendered to Medicaid beneficiaries. Between 1991 and 1993,
PSM billed Medicaid $142,560.17 using plaintiff’s provider number for services plaintiff did not provide and without plaintiff’s knowledge. MDCH sought repayment from both plaintiff and PSM for the overpayment amount because, under the Enrollment Agreement, they were jointly and severally liable for overpayments. At an administrative hearing, plaintiff was found to be jointly and severally liable for the entire overpayment amount. The circuit court affirmed the final decision of the MDCH.

The Michigan Court of Appeals reversed, holding that the circuit court misinterpreted the Social Welfare Act in finding plaintiff jointly and severally liable for the Medicaid overpayments because the claim forms did not meet the statutory certification requirements. Specifically, the claim forms did not contain plaintiff’s signature or the name of the person signing his name as was required by the Mich. Comp. Laws § 400.111b(17). The appeals court recognized that even though Section 400.111b(17) requires a provider to supervise an agent who submits claims on his behalf, including an employer as in this case, plaintiff should not be held liable for PSM’s fraudulent actions, which were outside the scope of the contractual agreement between plaintiff and employer, and the duty imposed on plaintiff under the law.


*Physician avoids joint and several liability for fraudulent claims submitted in his name when claims fail to comply with the strict statutory certification requirements.*

**Eighth Circuit Reverses District Court’s Denial of Preliminary Injunction and Stops Nebraska from Denying Transitional Medicaid Assistance to Low-Income Caretaker Relatives While Case Pending**

Transitional Medicaid Assistance (TMA) is a form of Medicaid for working families who are transitioning off of Medicaid, offering Medicaid eligibility for six months regardless of income. In October 2002, Nebraska changed the method for determining the income eligibility of caretaker relatives in its medical assistance program. The new law eliminated the old income counting method, called “stacking,” which allowed a family that did not qualify for Medicaid to be listed as two households so its income was spread out over two households. As a result, approximately 10,000 low-income caretaker relatives with earnings lost Medicaid, and Nebraska denied them TMA benefits.

In a class action claiming that the state violated federal law by denying TMA, the district court denied plaintiffs' motion for preliminary injunction, claiming that plaintiffs were not entitled to TMA because they were not covered by 42 U.S.C. § 1396u-1(a), (b) (SSA § 1931), and TMA is available only to those who lose § 1931 Medicaid eligibility. The district court rejected plaintiffs' argument that they fell within the § 1931 group because, if the state’s 1996 stacking methodology were applied, they would have met the 1996 AFDC income eligibility standard. Plaintiffs appealed to the Eighth Circuit, which reversed the district court’s denial of the motion, ruling that plaintiffs had shown a substantial likelihood of success on the merits.

*Kai v. Ross*, 336 F.3d 650 (8th Cir. 2003).
Low-income caretakers were entitled to a preliminary injunction to require Nebraska to continue their benefits under TMA while the underlying case proceeds.

Arizona Supreme Court Says Failure to Perfect Statutory Lien Precludes Enforcement as Lien Against Patient; Agreement May Be an Enforceable Contract

Thomas E. Blankenbaker, D.C., provided chiropractic services to Tommy Jonovich who was injured in an automobile accident. Jonovich and his attorney signed a “Medical Records and Doctor’s Lien” agreement (Agreement), in which Jonovich’s attorney was authorized to pay Blankenbaker out of any judgment or settlement funds. When the case settled, Blankenbaker demanded payment, but Jonovich contested the bills. Blankenbaker sued Jonovich for payment, and Jonovich counterclaimed, seeking a declaratory judgment that the Agreement was unenforceable because Blankenbaker had failed to record and thus perfect his lien in accordance with the Arizona healthcare provider lien statute. The trial court found the Agreement invalid, but the appeals court reversed.

The Arizona Supreme Court vacated the appeals’ court’s decision, finding that Blankenbaker did not have an enforceable statutory healthcare provider lien because he (1) did not file the lien with the county recorder, and (2) sought to impose the lien against the “injured person” rather than the person “liable for damages,” in violation of the Arizona healthcare provider statute. However, the Supreme Court found the lower court’s declaratory judgment ruling in error to the extent that it held that the Agreement was invalid for all purposes. The court noted that although the Agreement may not constitute a lien, Blankenbaker still could rely on the Agreement as a contract for payment allowing the provider to proceed against the patient even without a lien. Blankenbaker v. Jonovich, 71 P.3d 910 (Ariz. 2003).

Doctor’s lien agreement that was not filed with the county recorder constitutes an unperfected lien and is unenforceable as such, yet the same Agreement may still constitute a contract for payment that is actionable by a physician seeking payment for services rendered.

California Appeals Court Finds Patient Liable for Payment for “Ongoing” Treatment, but Limits Recovery to Half of Insurance Proceeds

Plaintiff, a medically indigent adult, slipped and fell in her apartment building and sought care at San Bernardino County Hospital (County). Plaintiff sued the apartment owner and settled for the policy limits of $100,000. Plaintiff then sought to expunge the lien on the proceeds asserted by the County for medical care rendered. The trial court denied plaintiff’s motion but the court of appeals reversed, holding the lien should be expunged, although not the extent asserted by plaintiff.

The California Court of Appeal found that, although a California statute affords a county the right to recover the reasonable value of medical services rendered, such a lien is enforceable only against judgments and not against settlements. However, the
County did have an enforceable lien under the Hospital Lien Act for “emergency and ongoing” medical care despite plaintiff’s assertion that the majority of County’s medical services were not for emergency or ongoing care but rather were following intervening chiropractic care not part of the County’s system. The appeals court held that such intervening treatment did not change the “ongoing” nature of the County’s care, so a lien could be asserted. However, another California statute limits the lien to 50% of the insurance proceeds. Therefore, the County could only seek $50,000 in recouped fees (50% of the $100,000 insurance proceeds) rather than its full $58,000 lien.


*California county hospitals may assert a lien under the Hospital Lien Act for emergency and ongoing services, but only up to 50% of the amount that may be satisfied with insurance proceeds.*

**D.C. Circuit Says CMS Was Not Required to Correct Mistake in Request for Exception to ESRD Composite Rate and Denial was Proper**

St. Luke’s Hospital applied for an exception to the prevailing end-stage renal disease (ESRD) composite rate, which can be done if higher treatment costs are attributable to certain criteria including “atypical service intensity.” The fiscal intermediary forwarded the request to CMS and recommended that the exception be granted. CMS denied the request. On appeal, the PRRB reversed the denial and determined that CMS had improperly applied the “isolated essential facility” regulation to St. Luke’s, which never claimed it was that type of facility. However, the CMS Administrator reversed the PRRB’s decision and held that St. Luke’s should have clearly identified the type of facility. St. Luke’s challenged the Administrator’s decision in federal court. The district court granted summary judgment to the Secretary, and St. Luke’s appealed.

The D.C. Circuit affirmed, stating it was reasonable for the Secretary to require accurate information from St. Luke’s. St. Luke’s also argued that there was clear and correct data elsewhere in the request, and CMS was required by its own rules to review “all the information submitted.” The appeals court determined that the burden was on St. Luke’s to provide correct information. The appeals court determined that it was not unreasonable for the Secretary to deny the request, and therefore the Secretary’s decision was neither arbitrary nor capricious.


*CMS had no responsibility to correct a hospital’s error in its application for an exception and therefore, denial was appropriate.*

**U.S. Supreme Court Says Consent Decree with State Is Enforceable**

The case stems from a class action filed by parents on behalf of their children against various Texas agencies for allegedly failing to provide federally mandated Medicaid benefits under the state’s version of the early and periodic screening, diagnostic, and treatment services (EPSDT) program. Plaintiffs and the state officials entered into a consent decree, setting forth a comprehensive plan for implementing the federal
statute that was far more detailed than the statute itself. Two years later, plaintiffs sought to enforce the decree, alleging that state officials had not fully complied. The court ordered the parties to outline possible remedies. The Fifth Circuit reversed, stating that the Eleventh Amendment barred the action because, regardless of whether the EPSDT program complied with the decree, plaintiffs failed to establish that the program violated the federal Medicaid Act.

The U.S. Supreme Court ruled that the Eleventh Amendment does not bar enforcement of a consent decree entered into by state officials and thus reversed, finding the decree enforceable under *Ex parte Young*, which recognized an exception permitting courts to award prospective injunctive relief against state officials acting in violation of federal law. The Court acknowledged legitimate concerns that remedies outlined in consent decrees could “improperly deprive future officials of their designated legislative and executive powers” and also “lead to federal court oversight of state programs for long periods of time even absent an ongoing violation of federal law.” These concerns, however, would be addressed sufficiently by a court’s equitable powers and discretion under federal civil procedure rules to modify a decree when circumstances change. *Frew v. Hawkins*, 124 S. Ct. 899 (U.S. 2004).

*Consent decrees with a state are enforceable because of recognized exception permitting prospective injunctive relief when state officials act in violation of federal law.*

**U.S. Court in Illinois Denies Disabled Adults’ Review of State Medicaid Documents Except in Certain Limited Instances**

Plaintiffs alleged that state officials refused to write letters seeking authorization for the addition of Intermediate Care Facilities for the Developmentally Disabled in the northern part of the state because it would cost more money than providing care at home. Plaintiffs sought to compel production of two categories of documents from defendants: (1) those relating to the extent the state failed to obtain federal matching and Medicaid funds for programs involving the developmentally disabled, and (2) those reflecting “any manner that the Illinois Medicaid Plan and/or Illinois Medicaid Waiver plan which services the developmentally disabled is not in compliance with ADA or the Rehabilitation Act.”

The U.S. District Court for the Northern District of Illinois denied plaintiff’s motion to compel in the first category except to the extent that an existing or a proposed state budget included efforts to obtain federal matching or Medicaid funding. The court rejected plaintiffs’ argument that federal matching and Medicaid funding that the state had not received during the relevant periods should be within the scope of “available resources” that can be used to accommodate them. Reviewing *Olmstead v. L.C. ex. rel. Zimring*, 527 U.S. 581 (1999), the court held that the scope of “available resources” is limited to the state’s mental health budget. The court also denied plaintiffs’ motion to compel in the second category except to the extent that they directly stated the Illinois Medicaid Plan and/or Illinois Medicaid Waiver plan servicing
the developmentally disabled is not in compliance with the ADA or RA. In addition, the
court found plaintiffs’ request failed to put the state officials on “reasonable notice of
what is called for and what is not” because the language was overbroad and
extremely vague.


Review of state Medicaid documents may be denied except in certain limited
instances. A request for documents which “reflect in any manner” noncompliance with
law is overbroad and too vague.

**Third Circuit Says New Jersey Properly Counted Trust in Determining Medicaid
Eligibility of Spouse Living in Nursing Home**

Plaintiffs, married couples living in New Jersey, challenged a change in state Medicaid
policy that treated community spouse annuity trusts (CSATs) as countable resources
for purposes of determining Medicaid eligibility for an institutionalized spouse.
Inclusion of CSATs resulted in plaintiffs’ asset levels being too high for the
institutionalized spouse to qualify for Medicaid.

The Third Circuit affirmed the district court’s dismissal of plaintiffs’ claims, citing
federal law that provides that the corpus of an irrevocable trust funded with marital
assets in which payments could be made for the benefit of the institutionalized spouse
“shall be considered resources available to the individual,” 42 U.S.C. §
1396p(d)(3)(B). The Third Circuit reasoned that CSATs fit squarely within the statute,
specifically, an irrevocable trust that produces a stream of income for the community
spouse that could be used for the institutional spouse’s benefit. With regard to
plaintiffs’ argument that New Jersey should be equitably estopped from applying the
policy change with regard to CSATs to them, the court held that plaintiffs had failed to
allege affirmative misconduct on the part of the government. Therefore, equitable
estoppel is not proper.


Among those resources considered to be available to an individual for purposes of
determining Medicaid eligibility is the corpus of an irrevocable trust that is funded with
marital assets in which payments could be made for the benefit of an institutionalized
spouse. Therefore, New Jersey’s treatment of community spouse annuity trusts in
denying certain individuals Medicaid eligibility was proper.

**U.S. Court in New York Dismisses Suit for Return of Medicare Reimbursement,
Holds Plaintiff Failed to Exhaust Administrative Remedies**

The Centers for Medicare and Medicaid Services (CMS) filed a claim against plaintiffs
in a medical malpractice action seeking reimbursement under Medicare’s Secondary
Payer statute (MSP) for expenses related to treatment provided and upon which the
malpractice action was based. Because plaintiffs could not settle the malpractice
action with the outstanding Medicare lien, they paid CMS the alleged overpayment.
Plaintiffs subsequently requested a waiver of the payment and return of the funds due
to hardship. CMS denied the request and affirmed its denial when plaintiffs requested
reconsideration. Plaintiffs requested a hearing before an administrative law judge, but a hearing was never scheduled. Plaintiffs then sued CMS, seeking a declaratory judgment that CMS had violated the MSP statute by exceeding its authority in seeking reimbursement and for wrongfully demanding and receiving the funds. Plaintiffs also sought injunctive relief directing CMS to pay back the amounts received. CMS filed a motion to dismiss and argued the court lacked subject matter jurisdiction because plaintiffs failed to exhaust their administrative remedies. The U.S. District Court for the Northern District of New York granted CMS’ motion to dismiss because the MSP requires Medicare beneficiaries to exhaust all of their forms of insurance before seeking Medicare benefits.


The right to judicial review of administrative decisions related to claims regarding reimbursement pursuant to the Medicare Secondary Payor statute arises under the Medicare Act. Therefore, plaintiffs must exhaust their administrative remedies before seeking judicial review.

**Tenth Circuit Declines to Issue Preliminary Injunction of Law Repealing Optional Medicaid Coverage for Legal Aliens**

 Plaintiffs, who are legal aliens, filed a class action against the Executive Director of the Colorado Department of Health Care Policy and Financing (Department), seeking declaratory relief that the eligibility requirements in Colo. Senate Bill 03-176 (“SB 03-176”) violate the Equal Protection Clause of the Fourteenth Amendment. Colorado has provided optional Medicaid coverage to all legal aliens beyond what was required by federal law until the passage of SB 03-176 in 2003, which would repeal the optional Medicaid coverage for legal aliens. Plaintiffs also requested an injunction permanently enjoining termination of their benefits. The district court granted the temporary restraining order, but later lifted it and denied plaintiffs’ motion for a preliminary injunction.

The Tenth Circuit affirmed the denial of the motion for a preliminary injunction, except on the issue of a class member’s right to a pre-termination hearing. The appeals court first addressed plaintiffs’ claim that SB 03-176 violates equal protection by discriminating between citizens and legal aliens, and that the alleged discrimination was subject to strict scrutiny. Defendant argued that the rational basis test applied because the state statute (1) was based on a federal statute, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and (2) was rationally related to a legitimate state interest. The appeals court determined that, when Congress exercises its power that is derived from certain constitutional provisions and inherent sovereign powers to legislate with regard to aliens, rational basis review applies. In the PRWORA, Congress chose to have one welfare system for citizens and another for aliens, and gave the states discretion within the alien category to include or not include some classes of aliens.

**Soskin v. Reinertson**, 353 F.3d 1242 (10th Cir. 2004).
Law repealing optional Medicaid coverage for legal aliens did not warrant injunctive relief.

VIII. PHYSICIAN PRACTICE ISSUES

New Jersey Supreme Court Says State Consumer Fraud Law Does Not Apply to Advertisements for Physician Services

Plaintiffs sued a laser vision clinic, its owner, and one of its physicians (collectively “defendants”), alleging violation of the New Jersey Consumer Fraud Act (CFA). The claim arose from the clinic’s allowing a physician who was not fully licensed to treat plaintiffs. The trial court granted defendants’ dismissal motion for the CFA claim, finding that the CFA does not reach claims about medical services. The appeals court reversed.

The New Jersey Supreme Court reversed the appellate division’s judgment. The high court noted that the New Jersey legislature has never amended the CFA to include advertising by professionals. The high court explained that *Neveroski v. Blair*, 141 N.J. Super. Ct. 365 (1976), was the first case to address the applicability of the CFA to professionals, and in that case the court held that the CFA did not apply to the misrepresentations of a real estate broker. The *Neveroski* court concluded that the legislature intended the CFA to apply to “the ordinary commercial seller of goods” and not to semi-professionals like real estate brokers. Because the legislature has never amended the CFA to respond to the judicial determination that the CFA does not apply to professionals that are acting within their professional capacity, the high court concluded that the legislature approved of the judicial treatment of professionals in connection with the CFA. Applying *Neveroski* to the facts in this case, the high court determined that the CFA did not apply to defendants’ advertising representations that the laser surgery was being performed by licensed physicians, and the trial court had not erred in dismissing the claims.


State consumer fraud law does not apply to advertisements for physician services.

IX. PROFESSIONAL RIGHTS ISSUES

California Appeals Court Finds That, Where Statutory Pre-Termination Hearing Right Exists, Post-Termination Hearing Is Insufficient and Injunction May Issue

California law sets forth a comprehensive process to be followed when a hospital intends to take adverse action against a physician’s privileges, and requires the physician be offered a hearing before the hospital takes “any proposed final action.” Cal. Bus. & Prof. Code § 809 et seq. Palo Verde Hospital’s (PVH) Board of Directors (Board) denied the re-appointment application of Hossain Sahlolbei, M.D., citing repeated disruptive behavior, lack of honesty on the reappointment application, and quality of care concerns. Although Sahlolbei was offered a hearing before an ad hoc
committee to review the decision, Sahlolbei instead filed an action in state court, seeking a preliminary injunction prohibiting the Board’s action and reinstating his privileges. The trial court denied the action, but the appeals court reversed.

In reversing, the California Court of Appeal noted that the language of § 809 requires that a physician be offered a hearing before an adverse final action is taken, and offering a hearing after the taking of such action is not sufficient. The court rejected PVH’s argument that the action was not “final” because the decision could have been overturned after the hearing before the ad hoc committee, noting that “an action that has already been taken is not a ‘proposed’ action merely because it may be overturned any more than a judgment rendered by a trial court is a ‘proposed’ judgment merely because it may be reversed on appeal.” Since plaintiff was likely to prevail on the claim that his procedural rights were violated because the hospital failed to conduct a pre-termination hearing, the preliminary injunction was appropriate. The hospital’s concern regarding quality of care issues related to plaintiff’s behavior could, if severe enough, be addressed through an immediate suspension, if necessary to prevent “imminent danger to the health of any individual” which is authorized by state statute.


*When state law mandates certain procedural requirements for termination of medical staff privileges, failure to comply with the required procedure cannot be cured by providing for later hearings.*

**U.S. Court in New York Dismisses Suit for Failure to Exhaust Administrative Remedies**

Saeeda Mahmud, M.D., purchased a practice through Bon Secours Community Hospital and entered into a lease for office space. Mahmud alleged that she became the target of racial remarks and disciplinary actions by a hospital ad hoc committee, which found Mahmud’s care to be substandard after a chart review and subjected her to a psychiatric evaluation. Independent peer reviews of the same charts found that Mahmud’s care was appropriate, and the psychiatric evaluation found no mental disorders. When Mahmud did not timely file her renewal for the office space, the hospital refused to renew her lease. Mahmud sued the hospital, claiming racial motivation for the failure to renew her contract and in blocking her efforts to obtain employment at other hospitals. The hospital moved to dismiss, arguing in part that Mahmud had failed to file her claim initially with the Public Health Council (PHC), as required by state law.

The U.S. District Court for the District of New York granted the motion. The court found that, under the state law a physician must challenge any termination of hospital privileges by filing a complaint with the PHC, and that this requirement applies to claims in which the physician is seeking damages in addition to injunctive relief. The court found reasonable the requirement of filing with the PHC first because of PHC’s expertise in determining if there was a proper medical reason that the physician’s privileges were terminated.

Physician’s claims against hospital dismissed because she failed to exhaust administrative remedies mandated by state law.

Maryland High Court Says Review of Decisions Related to Denial of Medical Staff Privileges Was Not Entitled to Deference Because Plaintiff Alleged Breach of Contract and Tort Claims
Prince George’s Hospital Center, a private hospital, decided not to extend provisional privileges of Cynthia D. Sadler, M.D., based on quality of care concerns. After hearing testimony and evaluating evidence, an ad hoc committee of the hospital concluded that the hospital had shown “by a preponderance of the evidence that the [Medical Executive Committee] acted properly in refusing to extend Dr. Sadler’s privileges.” The Board of Directors agreed with the recommendation. Sadler sued, alleging breach of contract and tort claims. The trial court granted summary judgment to the Hospital, noting that the “substantial evidence test” was the appropriate standard of review. The Maryland Court of Special Appeals agreed.

The Maryland Court of Appeals reversed, holding that use of the “substantial evidence test” was improper in this case. Noting that courts typically defer to hospital credentialing decisions on public policy grounds and reluctance to second-guess medical judgment, the high court distinguished the instant case, alleging contract and tort claims, from the more common action seeking an injunction to prevent enforcement of a credentialing decision. The instant case was concerned with whether the bylaws of a hospital constituted a contract between the medical staff member and the hospital. The contract, if one existed, related to the procedures and standards for terminating the relationship between the physician and the hospital, and did not require an evaluation of whether the Hospital’s decision was appropriate.


Allegations that the bylaws constitute a contract between a physician and a hospital, and claims related to tort liability, will be judged with less deference than will cases seeking an injunction in the medical staff privileges context.

Connecticut Appeals Court Says State Qualified Immunity Laws in Connection with Review of Physician Abrogate Common Law Absolute Immunity
Plaintiff sued Charlotte Hungerford Hospital for defamation and four defendant physicians for malicious submission of false affidavits after his license was suspended in 1998. Plaintiff alleged that the hospital submitted a false report to the National Practitioner Data Bank, asserting that defendants’ expressions of concern about him to the department of health were malicious and false. Defendants claimed state law qualified immunity and common law absolute immunity from the suit.

The Connecticut Court of Appeals affirmed the trial court in granting the hospital summary judgment but denying defendants' motion for the same. The court
determined that defendants had limited immunity under state law, but state law overrides any immunity under common law. The appeals court also stated that the denial of motion for summary judgment was not appealable. **Chadha v. Charlotte Hungerford Hosp.**, 822 A.2d 303 (Conn. App. Ct. 2003).

*This case demonstrates that express statutory enactment controls over contrary common law.*

**California Appeals Court Holds Hospital Did Not Act Arbitrarily or Capriciously in Denying Privileges to Physician**

Plaintiff physician sued Sharp Memorial Hospital (Sharp), alleging abuse of discretion and violations of his right to due process and fair procedure. Plaintiff claimed that Sharp’s Governing Board abused its discretion by revoking plaintiff’s temporary privileges upon learning that he was under quality-of-care review by Riverside Community Hospital and that he fell below the standard of care in six of seven filmed procedures. Plaintiff claimed that Sharp had violated due process in not meeting with him to discuss bylaw violations and asserted violations of his right to fair procedure when the chief of staff requested a list of plaintiff’s cardiology cases.

The California Court of Appeal, Fourth District, affirmed the trial court’s judgment in favor of the board. The court noted that the board sought all evidence possible before its decision. Plaintiff never formally requested the meeting he deemed “due process.” The appeals court also found that state law allows the disclosure of health records when a doctor is under review or when patient identification information has been removed. **Maheshwari v. Governing Bd.**, No. D039509, 2003 WL 1849368 (Cal. Ct. App. Apr. 10, 2003).

*Hospitals can use external quality-of-care reviews, filmed evidence, and normally confidential patient data to revoke staff privileges.*

**New York High Court Holds Physicians Who Told Nonpatient She Did Not Need Treatment Were Not Liable for Nonpatient’s Illness Because No Duty of Care Was Owed**

Plaintiff sued Montefiore Medical Center, the Hospital of Albert Einstein College of Medicine, and every physician that she talked to between the time she brought her friend to the hospital with meningitis and the time she contracted it herself. Plaintiff claimed that her friend’s doctors repeatedly told plaintiff not to worry about an immunization and that an infection control nurse at Einstein had contacted people who had come in contact with the meningitis patient, but had not contacted plaintiff. Plaintiff sued for negligence in failing to suggest treatment and for violations of state law on reporting and containing communicable diseases.

The New York Court of Appeals held that the hospitals were not vicariously liable for the actions of private physicians. The high court also overturned the appeals court’s
finding of duty for two of the physicians. The court did find that Einstein could be held vicariously liable for the infection control nurse’s failure to notify plaintiff. 


The determination of liability depends on whether a duty of care is owed. Generally, hospitals are not liable for private physicians and physicians have no duty to nonpatients.

**California Appeals Court Holds Medical Group’s Policy of Terminating Relationship With Patients Who Sue It For Malpractice Does Not Violate Anti-Discrimination, Unfair Competition Laws**

Plaintiffs sued two Scripps Clinic physicians for malpractice, then sued Scripps itself for requesting that Health Net Insurance assign plaintiffs to a different medical group upon the filing of the malpractice suit. Plaintiffs claimed breach of fiduciary duty, emotional distress, unfair competition, and discrimination.

The California Court of Appeal, Fourth Appellate District, upheld the trial court’s disapproval of Scripps’s noninterference in physician contracts yet manipulation of the Health Net contract. The court affirmed the emotional distress and breach of fiduciary duty claims, noting that plaintiffs had little time to find new physicians. However, the court rejected plaintiffs’ claim of unfair competition, stating that Scripps’s policy still allows patients to sue for malpractice. The court also granted Scripps summary adjudication on the Unruh Act discrimination claims, noting that exclusion of patient litigants is a legitimate business interest.


Physicians can terminate treatment if they give notice and reasonable time to find another physician. The issue remains open, however, whether the same holds in a community where physicians are scarce.

**California Supreme Court Says Agency May Only Grant Ten-Day Stay to Consider Petition for Reconsideration**

The California attorney general (AG), on behalf of the California Medical Board (Board), filed charges of negligence against the chief medical examiner of San Diego County (defendant), in connection with two autopsies. The Board adopted the ALJ’s recommendation that the charges be dropped. The AG filed a petition for consideration a few days before the Board’s order was to take effect, and then filed a request for a stay of the decision under Cal. Gov’t Code § 11521(a). The Board ordered a twenty-eight day stay to allow it time to consider the petition for reconsideration. Defendant filed a petition with the trial court for a writ of administrative mandate. The Board granted the AG’s petition for reconsideration, and the next day the trial court issued a writ of mandate ordering the Board to set aside the twenty-eight day stay. The trial court held the Board was entitled to grant only a ten-day stay under § 11521(a), and the order for reconsideration was void. The appeals court reversed, and defendant appealed.
The California Supreme Court reversed the appeals court’s judgment and held § 11521(a) unambiguously allows for only a ten-day stay. Section 11521(a) provides that an agency has the power to order reconsideration of the petition of any party for a thirty-day period after the decision is sent to the respondent. Section 11521(a) also provides that if additional time is needed to evaluate the petition before the expiration of the thirty-day period the agency can grant a stay for ten days. The high court agreed with defendant’s argument that “once a petition has been filed, any stay can only be ‘solely for the purpose of considering the petition’ and must be limited to 10 days.” The legislature intended that agencies would have only ten days to review a petition, said the high court.

**Bonnell v. Medical Bd.,** 8 Cal.Rptr.3d 532 (Cal. 2003).

*Once a petition for reconsideration of a decision by a California agency has been filed, only a ten-day stay may be granted to review the petition.*

**Wisconsin Appeals Court Upholds Indefinite Suspension of Physician’s License**

The Wisconsin Court of Appeals affirmed enforcement of a Wisconsin Medical Examining Board (Board) order indefinitely suspending plaintiff’s license to practice medicine and surgery due to allegations that his patient care had fallen below minimum standards. Plaintiff asserted in state trial court that the facts failed to show his lack of proper patient care and that the Board misinterpreted the law supporting the order requiring him to complete courses on record-keeping and prescribing medicines and to submit his patient records for physician review. The trial court affirmed the Board order. Following plaintiff’s official suspension for failing to comply with the order’s requirements, the trial court again rejected his claim for judicial review.

The appeals court upheld the Board’s order on three grounds. First, plaintiff could not challenge the order because of claim preclusion. Second, the appeals court found substantial evidence that plaintiff failed to meet the order’s specific requirements. Finally, the appeals court held that the administrative law judge who presided over the Board’s initial hearing into plaintiff had properly quashed one of plaintiff’s witness’ subpoena for lack of probative value, as the testimony concerned the standard for reviewing patient records, not whether plaintiff had complied with the order.


*The Wisconsin appeals court affirmed a Wisconsin Medical Examining Board order indefinitely suspending a physician’s license to practice medicine and surgery, holding that claim preclusion barred him from appealing the order and that, regardless, there was substantial evidence showing that he failed to comply with the order.*
X. PUBLIC FUNDING OF INDIGENT CARE

Arizona High Court Rules That Medicaid Reimbursement for Emergency Medical Conditions Terminates After Transfer to Sub-Acute Care, Even if Chronic Symptoms May Lead to Adverse Consequences if Not Treated

The Arizona Supreme Court consolidated three cases related to Medicaid reimbursement of care provided to undocumented aliens. Arizona’s Medicaid program is required to reimburse hospitals providing otherwise uncompensated care to undocumented aliens for emergency medical conditions. In each of the cases, the Medicaid program denied requests for reimbursement after the patients had been transferred from an acute care to a sub-acute care ward. Ultimately, the high court remanded the cases to their respective trial courts with instructions to determine whether the patients’ conditions satisfied the requirements in the statute that a patient have acute symptoms that are so severe that medical treatment is needed and if not provided, could put the patient’s health in jeopardy. The court clarified that chronic symptoms that would lead to adverse consequences if not treated do not constitute emergency medical conditions because it was never intended that Arizona’s Medicaid program be responsible for long-term care.


Emergency medical condition for which Medicaid reimbursement is required terminates when the patient is stabilized, even if continued treatment is necessary to avoid adverse consequences.

CMS Publishes Final Rule Revising Methodology for Determining Outlier Payments for Hospitals

CMS is reducing reimbursements to hospitals for expensive Medicare patients. Fiscal year 2004 brings a lower threshold for these high-cost “outlier” payments. Features of the June 9, 2003, final rule include:

- guidance on computing high cost and short stay outlier payments;
- a plan to give intermediaries instructions on identifying hospitals receiving too much outlier payment;
- authorization for these intermediaries to review and adjust payments;
- authorization for hospitals to request cost-to-charge ratio changes from intermediaries;
- requirements to use the latest cost report in calculating cost-to-charge ratio, starting October 1, 2003;
- the end of using state average cost-to-charge ratios to name the cost of hospitals with below-average cost-to-charge ratios.

Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems, 68 Fed. Reg. 34493 (Dep’t Health and Human Servs., Ctrs. for Medicare & Medicaid Servs., Final Rule June 9, 2003).
The final rule addresses concerns of hospitals with low costs while capping excessive Medicare bills.

U.S. Court in North Carolina Says Secretary Improperly Excluded Hospital’s Swing-Bed Days in DSH Eligibility Calculation
Under HCFA (now CMS) approval, plaintiff District Memorial Hospital of Southwestern North Carolina used some of its acute-care beds to provide temporary skilled nursing care from 1991-1997. While many of these nursing patients were low-income, plaintiff’s fiscal intermediary refused to count their days. Thus plaintiff was ineligible for Medicare funds for its disproportionate share of low-income patients.

The U.S. District Court for the Western District of Carolina granted plaintiff summary judgment. The court held that the CMS Secretary improperly excluded the swing bed patient days from the disproportionate share eligibility calculation for fiscal years 1991-1997. The Secretary cited 42 C.F.R. § 412.106, arguing that “patient days” are only “days attributable to areas of the hospital that are subject to the prospective payment system” and “areas” is intended to mean services covered under prospective payment. The court countered that the ordinary meaning of “area” is “a geographic region of the hospital”; the patients were treated within an acute care hospital and thus form part of the calculation. District Mem’l Hosp. v. Thompson, 261 F. Supp. 2d 378 (W.D.N.C. 2003).

Disproportionate share funds are not received easily. Still, whatever CMS’s intent, the plain interpretation of language matters.

U.S. Supreme Court Says Injunction Blocking Maine Rx Program Was Not Warranted
Pharmaceutical Research and Manufacturers of America filed suit, claiming that the Maine Rx Program violated the Commerce Clause and was pre-empted by the Medicaid Act. Maine intends to use bulk purchasing power to negotiate rebates from drug manufacturers, then reimburse pharmacies that sell discounted drugs.

The U.S. Supreme Court rejected the Commerce Clause challenge because Maine would not regulate the price of out-of-state transactions or impose a disparate burden on competitors. The Court also rejected the district court’s argument that the Medicaid Act pre-empted such a program. Justices found three Medicaid-related goals of the Maine Rx Program: it benefits the “medically needy,” it could reduce Medicaid expenses, and it could produce savings for high-volume purchasers. Pharmaceutical Research & Mfrs. v. Walsh, 538 U.S. 644 (2003).

If the Maine program is shown to compromise federal interests or have no Medicaid-related goal, this and similar state prescription drug programs may be subject to challenge.
Louisiana Appeals Court Affirms Judgment Against Accounting Firm for Failing to Obtain Maximum DSH for Hospital Client

Plaintiffs Drs. Jackie Huckabay and Fred Willis, owners of L.S. Huckabay MD Memorial Hospital, sued auditors, KPMG Peat Marwick LLP, for failing to recover maximum disproportionate share reimbursement. A potential purchaser reviewed the KPMG cost reports, and claimed to find approximately $1.5 million additional DSH reimbursement. KPMG argued that the hospital had constructive knowledge of the cause of action when it contracted the cost report review. KPMG also claimed the trial court could not find KPMG negligent, because it was operating within the standard of care. The Louisiana Court of Appeals, Second Circuit, affirmed the trial court’s judgment, finding KPMG liable for breach of contract under the theory that the hospital had contracted with KPMG to seek the maximum DSH and because KPMG failed to do so it breached its contract. The appeals court awarded the hospital $439,712 for cost report review fees.


Hospitals may successfully hold their auditors accountable for failing to prepare cost reports in a manner that produces the highest reimbursement permitted under the law.

Missouri Appeals Court Reverses Declaratory Judgment That Regulations on Review of Psychiatric Hospital Admissions Were Invalid and Says Regulations Were Not Arbitrary or Capricious

The Missouri Department of Social Services (DSS) ordered Psychiatric Healthcare Corp. of Missouri to pay back $92,445 in Medicaid payments, citing two DSS regulations governing the certificate of need reviews of treatment records. The trial court had held that the regulation allowing physician reviews to deny hospitalization without written standards violated due process and that the regulation imposing penalties for late or improper CON forms was too harsh and therefore was invalid.

The Missouri Court of Appeals, Western District, reversed the trial court’s judgment, upholding the regulations and ordering the hospital to pay back Medicaid for all but one of the patients in question.


Physician review of medical necessity that incorporates procedural safeguards may save a regulation from being deemed arbitrary and capricious. Harsh penalties designed to ensure compliance with regulations bear a rational relationship to legitimate goals.