

# RATH YOUNG PIGNATELLI

New Hampshire MGMA – February 10, 2010 - LEGAL UPDATE

## 1. STATE DEVELOPMENTS

### JUA Decision

In an opinion issued January 28, 2010, the Supreme Court of New Hampshire affirmed the lower court's order against the State of New Hampshire and in favor of the JUA policy holders. The lower court had declared Laws 2009, 144:1 (the "Act") unconstitutional. The Act requires the New Hampshire Medical Malpractice Joint Underwriting Association (JUA) to transfer a total of \$110 million to the State's general fund during fiscal years 200, 2010, and 2011.

The Supreme Court of New Hampshire concluded that because the Act substantially interferes with the current policyholders' contracts with the JUA, and is not reasonable and necessary to accomplish the legislature's stated public purpose, the Act constitutes a retrospective law that results in an impairment of contract in violation of the New Hampshire Constitution and is, therefore, unenforceable.

A link to the decision is below.

<http://www.courts.state.nh.us/supreme/opinions/2010/2010006tuttl.pdf>

Legislators immediately began discussing other ways to access the JUA surplus. Policyholders are discussing next steps. Lawyers are considering tax implications of the decision.

### Budget Cuts

On Friday, February 5, 2010, Commissioner Toumpas announced the first round of cuts for Health & Human Services totaling \$28 million. Additional cuts of at least \$15 million more will follow. Among many cuts to social services, the line-item explanation issued by the Department includes a reduction in interim hospital outpatient rates for certain hospitals, a reduction in the outpatient hospital radiology fee schedule, a suspension of outlier payments, a reduction of professional services fees to 80% Medicare, reimbursement of lab fees at 60% Medicare, suspension of catastrophic aid payments and a delay in outpatient cost settlement payments. Cuts are necessary due to increased Medicaid case loads and state revenue.

## 2. FEDERAL HEALTH CARE REFORM AND OTHER INITIATIVES

The status of national health care reform legislation is in limbo after the election of Scott Brown to fill the Massachusetts Senate seat formerly held by Ted Kennedy. Scott Brown's election gives the Republicans 41 votes in the Senate, which means that Democrats no longer have the filibuster-proof 60-vote majority needed to pass legislation without Republican support. Democrats are still hopeful that they can find a way to pass some type of reform legislation, and at his appearance at a Town Hall meeting in Nashua last Tuesday, President Obama vowed to continue with the reform effort.

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Several options are on the table for Democrats. One suggestion that has been made is that Democrats could focus on passing multiple, smaller pieces of legislation with broader support. Another option that has been discussed as a possibility is a procedural maneuver called reconciliation, which would allow the Senate to pass a “cleanup” bill with changes from the House with only 51 votes. In the event that the reconciliation process is used, it is likely that much of the substance of the reforms outlined in the January Legal Update will remain intact.

However, it remains to be seen whether Democrats will pursue this strategy, or what an alternative reform proposal might look like. But it is likely that health care reform has been put on hold for at least the immediate future, and that it could be a matter of months before we have a clearer picture of the direction forward. The President has suggested bipartisan discussions.

In the meantime, the President’s FY ‘11 budget seeks to reduce waste in the Medicare and Medicaid programs, seeking \$11.7 billion to combat fraud. The Executive Branch promises zealous enforcement. It increases funding by \$250 million over last year for fighting Medicare and Medicaid fraud. It seeks funds to expand the Strike Force Teams. And it includes a series of proposals to strengthen oversight and step up efforts to prevent fraud. These “program integrity proposals” include:

- Modifying medical review limitations;
- Establishing a Centers for Medicare & Medicaid Services-Internal Revenue Service collaboration to identify providers who have not filed federal income tax returns;
- Extrapolating Medicare Advantage sample error rates for all plan payments;
- Tracking drug utilizers and providers to cut down on overutilization;
- Consolidating medical review;
- Consolidating Medicare provider enrollment activity; and
- Expanding Medicare revocations.

With the increased governmental focus on detecting and prosecuting health care fraud, it is important that health care providers resist any urge to cut their compliance budget lines. Ongoing compliance efforts are more important than ever.

Senator Grassley has also submitted a bill to combat healthcare fraud by strengthening provider screening requirements, reducing claims submission to one year, enhancing penalties and requiring overpayments to be paid within sixty (60) days of discovery.

### 3. OTHER FEDERAL DEVELOPMENTS

#### Red Flags Rule

In recent litigation brought by the American Bar Association against the FTC, the U.S. District Court for the District of Columbia ruled that the Red Flags Rule does not apply to lawyers. The Court focused its decision on the argument that lawyers were distinguishable from financial institutions and should not be considered “creditors,” and the unique privileged relationship between lawyers and clients. In the wake of that decision, four national organizations have jointly petitioned the Federal Trade Commission to make it clear that the Rule will not apply to their members either. The organizations are the American Medical Association (AMA), the American Osteopathic Association (AOA), the American Dental Association (ADA), and the American Veterinary Medical Association (AVMA). In the absence of further action by the FTC, enforcement of the Red Flags Rule will commence June 1, 2010.

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A copy of the AMA/AOA/ADA/AVMA letter to the FTC can be found at <http://www.ama-assn.org/ama1/pub/upload/mm/399/ftc-letter-red-flags.pdf>.

#### 4. CHECK HHS EXCLUSION WEBSITE

A New Hampshire hospital and a temporary staffing agency will pay the federal government \$123,400 to resolve allegations they employed a nurse who was barred from participating in federal health care programs. There is no evidence any patient was harmed or put in jeopardy.

All providers should, pre-hire and routinely thereafter, check the OIG website for excluded individuals. The website is: <http://oig.hhs.gov/fraud/exclusions.asp>.

#### 5. MEDICARE

##### **Advanced Diagnostic Imaging Supplier Accreditation Program**

The Centers for Medicare & Medicaid Services (CMS) has announced its initial approval of three national accreditation organizations to accredit suppliers of the technical component of advanced imaging services to Medicare patients:

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC)

Suppliers (including physicians) of the technical component of advanced diagnostic imaging services must become accredited by a designated accreditation organization by January 1, 2012. Advanced diagnostic imaging services include diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine, including positron emission tomography (PET).

CMS's notice was published in the Federal Register on January 26, 2010 (75 Fed. Reg. 4088).

##### **Updated Fraud Alert on DME Telemarketing**

The OIG has published an updated Special Fraud Alert on Telemarketing by Durable Medical Equipment (DME) Suppliers.

Section 1834(a)(17)(A) of the Social Security Act prohibits unsolicited telemarketing by a DME supplier to Medicare beneficiaries, whether contact with the beneficiary is made by the supplier directly or by another party on the DME supplier's behalf, except in three specific situations:

- The beneficiary has given written permission to the supplier to make contact by telephone;
- The contact is regarding a covered item that the supplier has already furnished to the beneficiary; or
- The supplier has furnished at least one covered item to the beneficiary during the preceding 15 months.

The Act prohibits payment to a supplier that knowingly submits a claim generated pursuant to a prohibited telephone solicitation; any such claims are false claims and violators are potentially subject to criminal, civil and administrative penalties.

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The Updated Special Fraud Alert can be found at 75 Fed. Reg. 2105 (January 14, 2010).

### 6. AMERICANS WITH DISABILITIES ACT

#### Disability Discrimination – Employers' Obligations

##### ADA

The federal Americans with Disabilities Act of 1990 ("ADA Title 1") prohibits employers from discriminating against qualified job applicants with disabilities when hiring and qualified employees with disabilities with respect to training, firing, wages, promotions, benefits or any other aspect of employment. 42 U.S.C.A. §12112(a). The ADA defines "disability" as a physical or mental impairment that substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment. 42 U.S.C.A. §12112(b)(5)(A) and (B).

In addition, the ADA requires employers to make reasonable accommodations for the known physical and mental limitations of qualified employees or applicants with disabilities unless the accommodations create undue hardship. Employers are prohibited from refusing to hire an applicant who is disabled if such a refusal is based on the need for the employer to make reasonable accommodations for the applicant. **Reasonable accommodations** may include (a) making existing facilities readily accessible to and usable by individuals with disabilities; and (b) job restructuring, modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations.

Employers may not be required to make reasonable accommodations if the employer can demonstrate that the accommodation would impose an **undue hardship** on the operation of the business. The term "undue hardship" is defined, generally, as an action requiring significant difficulty or expense, when considered in light of the following factors: (1) the nature and cost of the accommodation, (2) the overall financial resources of the facility involved and the impact of the accommodations on such a facility, (3) the overall financial resources of the employer, and (4) the type of operations of the employer.

Under the ADA, employers can refuse to hire applicants with disabilities and terminate employees with disabilities who pose a **direct threat** to themselves or others. A "direct threat" includes a current significant risk of substantial harm to themselves or others that is based upon objective facts or medical evidence and cannot be eliminated or reduced through reasonable accommodations. Chevron U.S.A., Inc. v. Echazabal, 536 U.S. 73 (2002).

The ADA applies to employers who employed fifteen or more full or part-time employees during any twenty-week period during the current or previous calendar year. (Note that New Hampshire's "Law Against Discrimination," R.S.A. §354-A, applies to employers that employ six or more individuals.)

##### ADAAA

On September 25, 2008, President George W. Bush signed the Americans with Disabilities Act Amendments Act of 2008 ("ADAAA"). The ADAAA was intended to overturn a series of Supreme Court decisions that interpreted the ADA in a way that made it difficult to prove that an impairment was a "disability." The ADAAA went into effect on January 1, 2009.

The ADAAA retains the ADA's basic definition of "disability" noted above; however, the ADAAA emphasizes that the definition of "disability" should be construed in favor of a broad coverage of individuals, to the maximum extent permitted

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by the terms of the ADA, and generally shall not require an extensive analysis. The main focus under ADAAA is now on whether discrimination occurred, not on who qualifies as having a disability. The ADAAA does not alter the definition of “disability” to accomplish these changes, instead it alters the way that the statutory terms should be interpreted.

- Employers should review job descriptions and ensure accuracy.
- Employers should focus employment decisions on performance and conduct.
- Employers should be trained to refrain from discussing medical conditions that are not material to the workplace but to recognize requests for accommodations.

### **Health Care Providers’ Obligations to Make Accommodations for Deaf or Hard of Hearing Patients and Family Members**

#### **A. Background.**

Title III of the ADA prohibits discrimination against the disabled, by providing “no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.” “Public accommodations” include the professional office of a healthcare provider, hospital or other service establishment operated by a private entity, whose operations affect commerce. (Note: Section 504 of the Rehabilitation Act, which applies to healthcare entities that receive federal financial assistance, including Medicare and Medicaid payments, prohibits disability discrimination as well.)

#### **B. Requirements.**

##### **i. Auxiliary Aids.**

Providers must make auxiliary aids and services available to enable “effective communication” with patients or family members who have physical or mental impairments, including hearing impairments that substantially limit their ability to communicate. Commentators have noted that effective communication with the deaf and hard of hearing is necessary to ensure proper diagnoses and treatment, and establish informed consent.

Depending on the circumstances and patient, the auxiliary aids and services may include written materials, telephone handset amplifiers, assistive listening devices, telephones compatible with hearing aids, open and closed captioning, telecommunications devices for deaf persons (“TDDs”) or “qualified interpreters” able to communicate through sign language.

To be “qualified” under the ADA, sign language interpreters need not be certified, however, they do need to be licensed under New Hampshire law.

Providers may not typically rely on family members of the deaf individual to serve as sign language interpreters, because emotional and personal involvement may prevent them from providing impartial, accurate or effective interpreting.

Although compliance may result in additional costs, according to regulations, a public accommodation may not place a surcharge only on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses. Accordingly, if a provider arranges for the services of a qualified sign language interpreter, in order to ensure effective communication with a deaf patient during an office visit, the provider must absorb the cost of the interpreter’s services.

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Neither Title III nor the regulations promulgated thereto excuse public accommodations, including healthcare providers and hospitals, from the requirements of Title III merely based on the size of the office or the number of staff. However, public accommodations need not provide a particular auxiliary aid in all circumstances.

For example, the regulations excuse public accommodations from providing a particular auxiliary aid or service if it results in a fundamental alteration in the nature of the services or is an undue hardship. However, if a particular auxiliary aid would fundamentally alter the nature of the services or present an undue hardship, the healthcare provider or hospital must provide an alternative auxiliary aid or service if one exists. (Note that a provider can deny service to the disabled person if the provider determines that the person poses a direct threat to the safety and welfare of others.)

Generally, in the case of a healthcare provider, a “fundamental alteration of the nature of the services” arises when providers are forced to treat patients or conditions outside their specialty. Also, note that the cost of the treatment alone may not excuse the healthcare provider from its obligation to pay for an interpreter. In 2008, a New Jersey court held that a \$200 per visit interpreter’s fee was not an undue hardship for a solo practitioner simply because the cost of the interpreter exceeded what the provider would have received as payment for services.

The question of when an interpreter is required depends on the facts and circumstances of each case. Through its Technical Assistance Manual, the Department of Justice has taken the position that public accommodations, which would include healthcare providers, should consult with disabled individuals when possible to determine what type of auxiliary aid is needed. In many cases, more than one type of auxiliary aid or service may make effective communication possible, and the ultimate decision as to what measures to take “rests in the hands of the public accommodation, provided that the method chosen results in effective communication.” Note, however, that a patient that disagrees with the determination that the auxiliary aid will lead to effective communication may challenge that decision under Title III by initiating litigation or filing a complaint with the Department of Justice.

The Department of Justice has provided a list of examples (which we have labeled Illustrations 1 through 5) illustrating when a healthcare provider must provide a qualified interpreter.

### ii. Examples.

#### Illustration 1:

*“A patient who is deaf brings his own sign language interpreter for an office visit without prior consultation and bills the physician for the cost of the interpreter. The physician is not obligated to comply with the unilateral determination by the patient that an interpreter is necessary. The physician must be given an opportunity to consult with the patient and make an independent assessment of what type of auxiliary aid, if any, is necessary to ensure effective communication. If the patient believes that the physician's decision will not lead to effective communication, then the patient may challenge that decision under Title III by initiating litigation or filing a complaint with the Department of Justice.”*

From Technical Assistance Manual, available at: <http://www.ada.gov/hospcombrprt.pdf>.

#### Illustration 2:

*“H goes to his doctor for a bi-weekly check-up, during which the nurse records H's blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.*

*BUT: Upon experiencing symptoms of a mild stroke, H returns to his doctor for a thorough examination and battery of tests and requests that an interpreter be provided. H's doctor should arrange for the services of a qualified interpreter,*

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as an interpreter is likely to be necessary for effective communication with H, given the length and complexity of the communication involved.”

From Technical Assistance Manual, available at: <http://www.ada.gov/hospcombrprt.pdf>.

### Illustration 3:

*“Written forms or information sheets may provide effective communication in situations where there is little call for interactive communication, such as providing billing and insurance information or filling out admission forms and medical history inquiries.*

*For more complicated and interactive communications, such as a patient’s discussion of symptoms with medical personnel, a physician’s presentation of diagnosis and treatment options to patients or family members, or a group therapy session, it may be necessary to provide a qualified sign language interpreter or other interpreter.”*

From ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings, available at <http://www.ada.gov/hospcombrprt.pdf>.

### Illustration 4:

*“Situations where an interpreter may be required for effective communication:*

- *discussing a patient’s symptoms and medical condition, medications, and medical history*
- *explaining and describing medical conditions, tests, treatment options, medications, surgery and other procedures*
- *providing a diagnosis, prognosis, and recommendation for treatment*
- *obtaining informed consent for treatment*
- *communicating with a patient during treatment, testing procedures, and during physician’s rounds*
- *providing instructions for medications, post-treatment activities, and follow-up treatments*
- *providing mental health services, including group or individual therapy, or counseling for patients and family members*
- *providing information about blood or organ donations*
- *explaining living wills and powers of attorney*
- *discussing complex billing or insurance matters*
- *making educational presentations, such as birthing and new parent classes, nutrition and weight management counseling, and CPR and first aid training.”*

From ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings, available at <http://www.ada.gov/hospcombrprt.pdf>.

### Illustration 5:

*“Hospitals may need to provide an interpreter or other assistive service in a variety of situations where it is a family member or companion rather than the patient who is deaf or hard of hearing. For example, an interpreter may be necessary to communicate where the guardian of a minor patient is deaf, to discuss prognosis and treatment options with a patient’s spouse or partner who is hard of hearing, or to allow meaningful participation in a birthing class for a prospective new father who is deaf.”*

From ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings, available at <http://www.ada.gov/hospcombrprt.pdf>.

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### C. Consequences of Noncompliance.

The Department of Justice is required to conduct investigations and enforcement actions. Additionally, private rights of action exist under Title III, which allow “any persons” subject to disability discrimination, or who have reasonable grounds for believing they are about to be subject to discrimination, to bring suit.

Compensatory damages, including noneconomic compensatory damages, are available in cases of intentional discrimination. Additionally, in certain cases, where the provider refuses to comply with the mandates of Title III, or to cooperate in compliance investigations, suspension or termination of participation in federal financial programs may result.

In 2008, Concord Hospital entered a settlement agreement with the DOJ requiring Concord Hospital to, among other things, provide qualified interpreters within certain timeframes. The hospital was also required to pay a total of \$100,000 in compensation to the six plaintiffs.

In the 2008 New Jersey case discussed above, a jury awarded the deaf patient \$400,000, including \$200,000 in punitive damages, against the solo practitioner that failed to provide a sign language interpreter at the patient’s request. Moreover, it appears that the physician may be personally liable as his malpractice carrier denied coverage as well as a defense.

### D. Limited English Proficiency.

A separate but related issue is whether deaf or hard of hearing patients or family members qualify for protection based on their limited English proficiency (“LEP”). Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d to 2000d-7) and the regulations promulgated thereto (28 C.F.R. § 42.101 *et seq*), together with Executive Order 13166, require certain programs and activities that receive federal financial assistance to improve access to services by individuals with limited English proficiency.

Generally, “federal financial assistance” includes grants, training, use of equipment, donations of surplus property, and other assistance. Recipients of such assistance typically include hospitals, nursing homes, home health agencies, managed care organizations, universities, state Medicaid agencies, state and local welfare agencies, vendors and other entities with health or social service research programs. Recipients of federal financial assistance do not include, for example, providers who only receive Medicare Part B payments.

The U.S. Department of Health and Human Services has issued guidance to help providers assess their obligation to provide language assistance for LEP patients. According to this guidance, healthcare providers should evaluate the following factors to determine what language assistance is appropriate:

- The number or proportion of LEP persons eligible to be served or likely to be encountered by the practice;
- The frequency with which the LEP individuals come in contact with the practice;
- The nature and importance of the program, activity or service provided by the practice to people’s lives; and
- The resources available to the practice and costs.

The guidance is available at:

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

A summary of the guidance can be found at: <http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html>.

See also the AMA’s Office guide to communication with limited English proficient patients, available at:

[http://www.ama-assn.org/ama1/pub/upload/mm/433/lep\\_booklet.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf).

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### E. Conclusion.

Title III of the ADA requires healthcare providers and hospitals, regardless of size, to provide qualified sign language interpreters to deaf or hard of hearing patients or family members when necessary to achieve effective communication. When an interpreter is necessary for effective communication will depend on the facts and circumstances of each case. Ultimately, the decision of whether or not to provide a qualified sign language interpreter rests with the healthcare provider, however the patient can challenge the provider's determination through litigation, and the consequences of an adverse result can be expensive.

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