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# HEALTH LAW NOTES

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## LMMA DOES NOT APPLY TO EMTALA

The Louisiana Medical Malpractice Act (LMMA) mandates that all malpractice complaints against qualified health care providers first be submitted to a medical review panel prior to filing a lawsuit. The LMMA also provides a limitation of liability, or "cap," on a qualified health care provider's liability for amounts in excess of $100,000, for all malpractice claims for injuries or death of any one patient.

The LMMA, however, only applies to claims for "malpractice," which is defined as "any *unintentional tort*". Consequently, many legal battles are fought over whether a claim arises out of conduct that is intentional or unintentional. The outcome of these legal battles determines whether a qualified health care provider enjoys the protections or "cap" afforded under the LMMA.

> *...damage awards under EMTALA are not limited by the LMMA because EMTALA claims are not established by "traditional notions of negligence"*

Recently, a Louisiana federal court found that the Emergency Medical Treatment and Active Labor Act (EMTALA) gives a person the right to sue certain health care providers for their unintentional torts and effectively get around the protections of the LMMA.

In *Jeff v. Universal Health Services, Inc.*, 04-1507 (E.D. La. July 27, 2005), the court was presented with a factual scenario where a person went to his doctor's office complaining of a persistent cough. The patient was diagnosed with bronchitis and given a prescription for antibiotics. Shortly afterwards, he continued to feel weak, short of breath and was having difficulty walking. He went to an emergency room where, allegedly, he was told the wait would be several hours and the physician refused to see him. Thereafter, he left the emergency room without treatment and went home. The following day, he again went to the emergency room and was subsequently hospitalized for two days until he died.

Subsequently, the decedent's heirs filed suit in federal court against the hospital under EMTALA, and indicated to the court that they also intended to bring a claim in state court for medical malpractice.

As part of its legal defense, the hospital filed a motion for partial summary judgment on the question of whether possible damages in the EMTALA claim are limited by the LMMA "cap." The federal court, denying the hospital's motion, held that damage awards under EMTALA are not limited by the LMMA because EMTALA claims are not established by "traditional notions of negligence". Rather, EMTALA imposes a strict liability for refusal to treat and does not incorporate the state's procedural limitations for malpractice actions.

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## LOUISIANA LEGISLATURE CONSIDERS STATE STARK LAW

One interesting bill to watch during the 2006 Regular Session of the Louisiana Legislature is Senate Bill 570 (SB 570) sponsored by Senator Don Hines of Bunkie. Similar to the federal physician referral prohibition known as the Stark Law after its author Congressman Pete Stark of California, SB 570 prohibits physicians from referring their patients to health care facilities in which the physician or an immediate family member of the physician maintains a direct or indirect ownership interest. This referral pro-hibition would only apply if the physician provides services in the primary service area of a rural hospital and the health care facility in which the physician has an ownership interest is also located in the primary service area of any rural hospital. The primary exception to the referral prohibition in SB 570 is if the rural hospital in whose primary service area the new health care facility is located is offered the option to participate in the ownership of the health care facility.

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# DEFICIT REDCUTION ACT OF 2005 IMPOSES SIGNIFICANT CHANGES FOR HEALTH CARE PROVIDERS

The Deficit Reduction Act of 2005 (DRA), signed by President Bush on February 8, 2006, is projected to reduce payments to health care providers through the Medicare and Medicaid programs by over 10.7 billion over the next five years. The changes in reimbursement from the DRA will impact several types of health care providers, including physicians, hospitals, diagnostic imaging service providers, Ambulatory Surgery Centers (ASCs), home health agencies, and Durable Medical Equipment (DME) suppliers.

One significant aspect of the DRA is that it delays implementation of a scheduled 4.4% payment reduction for physician services in 2006. The DRA requires payments for physician's services to remain at the amounts for 2005 through 2006. Medicare carriers will also be required to repay physicians for the difference between the amounts paid at the beginning of 2006 according to the 4.4% reduction and the newly inflated amounts effective retroactively to the start of 2006.

The DRA provides that payment rates for imaging services delivered in physician offices and independent diagnostic testing facilities (IDTFs) may not exceed payment rates for identical imaging services furnished in hospital outpatient departments effective January 1, 2007. Diagnostic imaging services affected by this cap include: imaging and computer-assisted imaging services, including X-ray, ultrasound (e.g., echocardiography), nuclear medicine (e.g., positron emission tomography), MRI, CT, and fluoroscopy; however, diagnostic and screening mammography is excluded from this cap.

For ASCs, the DRA provides that payment rates for services delivered in ASCs may not exceed payments for the same services in hospital outpatient departments under the Medicare hospital outpatient prospective payment system. This cap for ASC payments will be in effect until Medicare establishes a new payment system for ASCs.

For DME suppliers, the DRA provides that title to rented DME items, such as hospital beds, now automatically transfers to the beneficiary after the 13th month of consecutive rental. This change effectively converts the current option to rent DME into a rent-to-own program and beneficiaries will now effectively purchase all items of DME after a 13-month rental period.

The DRA includes an additional $100 million in fiscal year 2006 for the Medicare Integrity Program, which funds anti-fraud and abuse investigation efforts. The DRA also provides that all entities that receive at least $5 million in Medicaid payments must establish written policies and procedures for all employees, contractors and agents regarding the organization's protocols for fraud detection and prevention as well as for informing them about the False Claims Act, whistleblower protections and other enforcement authority regulations. This is the first regulation to effectively require compliance as a condition of payment for receiving reimbursement under the Medicare and Medicaid program.

For physician-owned specialty hospitals, the DRA requires the Secretary of HHS to develop a plan to address the following issues concerning physician investment in specialty hospitals: (1) proportionality of investment return; (2) bona fide investment; (3) annual disclosure of investment information; (4) provision of care to Medicare beneficiaries; (5) charity care; and (6) appropriate enforcement. This plan must be submitted by HHS to Congress by August 8, 2006.

The DRA also contained several provisions that will implement significant changes in pharmacy reimbursement, and procedural and substantive changes to the Medicaid rebate program .change will affect Medicaid pharmacy reimbursement and drug rebate programs.

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