

New Jersey Court Gives Access to Non-Party Emergency Room Records

On April 15, 2009, the United States District Court for the District of New Jersey, in *Gonzalez v. Choudhary* (2009 U.S. Dist. LEXIS 32342 (D.N.J. 2009)), expanded the boundaries of discovery under the particular circumstances of a pending Emergency Medical Treatment and Labor Act (EMTALA) case by ordering the South Jersey Healthcare Regional Medical Center (the hospital) to produce the medical records of other hospital patients similarly situated to the plaintiff in the *Gonzalez* case, as potentially relevant to her claim for alleged disparate treatment in the emergency room at the hospital.

EMTALA provides as follows with respect to a medical screening:

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not

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an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 U.S.C. §1395dd(e).

Grisselle Gonzalez alleged that the hospital violated EMTALA by failing to provide her with an appropriate medical examination during her emergency room visit because of her "lack of insurance, indigency, appearance, race, gender and/or age," and argued that discovery of other patients' records would provide her with the only means of ascertaining the hospital's standard screening procedures for purposes of proving that she received disparate treatment. Because the hospital did not have a specific written policy for screening patients with chest pain, the court held that the emergency room records of similarly situated patients, i.e., patients who presented with the chief complaint of chest pain within a two-week period prior to the plaintiff's treatment, were relevant to Gonzalez's EMTALA claim and subject to discovery.

The effect of this decision must be viewed in the context of the facts presented by the case: Gonzalez visited the hospital's emergency room complaining of chest pain and shortness of breath. After examining Gonzalez, a staff physician diagnosed her with extra-pyramidal symptoms and dystonia, but allegedly failed to provide her with

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“adequate cardiac testing” or “supplemental oxygen, nitroglycerine, or aspirin” prior to her hospital discharge. Feeling that her symptoms had not dissipated, Gonzalez returned to the emergency room two days later and suffered cardiac arrest while waiting to be seen.

In her ensuing lawsuit against the hospital for negligence and alleged violation of EMTALA, Gonzalez filed a motion to compel the production of redacted medical records for patients who had presented to the hospital’s emergency room with similar complaints during the same general time period as her visit. In deciding Gonzalez’s motion to compel, the court noted that a “key requirement” of a hospital’s duty under EMTALA is to screen all emergency room patients uniformly, “regardless of whether they are insured or can pay.” The court stated that a plaintiff can potentially meet the burden of proving non-compliance with that duty through “sources other than the express standard policies” of the defendant.

The court found that the medical records of other patients presenting at the hospital’s emergency room with similar symptoms could, potentially, be probative of Gonzalez’s claim that she was not given equal and appropriate screening during her visit. In granting Gonzales’ motion, the court also rejected the hospital’s argument that there was no need to produce other patients’ records because it had already produced its general written policies for screening patients in prior discovery. The court held that “in the absence of documents setting forth *particular screening procedure for patients complaining of chest pain,*” Gonzales was entitled to discovery of other patients’

records to determine whether the screening she received was different than what the hospital provided to others.

The *Gonzalez* decision cannot be read as meaning that the records of non-parties will be discoverable in any EMTALA case where disparate emergency room treatment is being claimed. It is clear, however, that not having a written, symptom-specific policy for screening emergency room patients can open the door to court-mandated production of other patients’ records in an EMTALA case. To avoid such problematic discovery obligations, hospitals should be sure to maintain policies delineating symptom-specific screening procedures for emergency room treatment. Maintenance of such written policies will not only minimize the risk of being compelled to produce other patients’ medical records as occurred in the *Gonzalez* case, but may also protect against the risk of a negligence claim for not having such a policy in place for proper emergency room care.

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Peppercast: Plenary Guardian Blocked from Declining Life-Sustaining Medical Care by Pennsylvania Court

In this podcast, Kathleen Huang, an attorney in the Trusts and Estates Practice Group of Pepper Hamilton, discusses *In re D.L.H.*, a matter where the Pennsylvania Superior Court held that a court-appointed plenary guardian does not have inherent legal authority to decline life-sustaining medical care on behalf of an incapacitated adult who is not suffering from an end-stage medical condition.

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False Claims Act Expansion to Affect Health Care Providers

President Obama recently signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA), which grants the federal government the ability to investigate and prosecute frauds related to federal assistance and relief programs, including the Troubled Asset Relief Program (TARP). Section 4 of FERA also brings sweeping changes to the False Claims Act (FCA), 31 U.S.C. §3729 *et seq.* Health care providers that submit Medicare or Medicaid claims for payment should be aware of the following FCA amendments:

Intent of the Claimant

Before FERA, §3729(a)(2) of the FCA imposed liability for knowingly making, using or causing to be made or used “a false record or statement to get a false or fraudulent claim paid or approved by the Government.” Congress amended this “intent” requirement in response to the Supreme Court’s decision in *Allison Engine Co. v. United States ex rel. Sanders*, 128 S.Ct. 2123 (2008).

In *Allison Engine*, former employees of a Navy subcontractor alleged their employer submitted fraudulent certificates of compliance, but could not prove that the fraudulent certificates were issued for the purposes of obtaining payment. In overturning the Sixth Circuit’s ruling, the Court held that it was not enough for a FCA claimant to show that a false statement resulted in payment; it was required that the defendant *intended* for the false statement to result in payment by the government.

Section 4 of FERA introduces new subsection §3729(a)(1)(B), which imposes liability for knowingly making, using, or causing to be made or used “a false record or statement *material to a false or fraudulent claim.*” To be “material,” a false record or statement must have “a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” Health care providers submitting false claims for payment by the government may be liable under FCA even if they do not specifically intend to defraud the government. Providers also should be aware that this provision of FERA applies retroactively to June 7, 2008, the date of the *Allison Engine* decision.

Enforcement of FTC’s Red Flags Rules Delayed (Again) Until August 1

The Federal Trade Commission (FTC) announced that it will delay enforcement of the Red Flags Rules for an additional three months until August 1, 2009. Enforcement of the identity theft rules was originally set for November 1, 2008, and was first delayed until May 1, 2009, due to agency concerns that certain industries (such as health care) were confused about their coverage under the rules.

In connection with the FTC’s April 30 announcement of the delay, FTC Chairman Jon Leibowitz said, “Given the ongoing debate about whether Congress wrote this provision too broadly, delaying enforcement of the Red Flags Rule will allow industries and associations to share guidance with their members, provide low-risk entities an opportunity to use the template in developing their programs, and give Congress time to consider the issue further.”

The Red Flags Rules require financial institutions and creditors to develop a written program to identify, prevent, and mitigate identity theft. The term “creditor” has been defined broadly and applies to a wide variety of organizations including many in the health care industry. A detailed overview of covered entities and the components of a written identity theft prevention program was presented in a previous *Pepper Health Care Law Update*, available at http://www.pepperlaw.com/publications_update.aspx?ArticleKey=1312.

Shortly after announcing the latest enforcement delay, the FTC released a template program (available at <http://www2.ftc.gov/bcp/edu/microsites/redflagsrule/get-started.shtm>). The interactive template is intended to help covered entities with a low risk for identify theft to comply with the Red Flags Rules and to develop an identity theft prevention program.

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Presentment of Claims

Section 3729(a)(1) of the FCA previously imposed liability on anyone who “knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces” a false claim. In *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488 (D.C. Cir. 2004), the FCA plaintiff alleged that two contractors overcharged Amtrak for defective railroad cars. The D.C. Court of Appeals held that there was no FCA liability since the fraudulent bills were not directly submitted to the federal government, which subsidizes Amtrak. In response to *Totten*, Congress removed the §3729(a) requirement that claims be presented directly to the federal government in order for liability to attach. Pursuant to FERA, new subsection §3729(a)(1)(A) imposes liability on “any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” This new provision of FERA impacts providers who receive payment under Medicare and Medicaid through intermediaries, contractors and states.

Obligation to Pay

An additional FCA change directly affecting health care providers is FERA’s definition of an “obligation.” Former §3729(a)(7) provided liability if anyone “knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.” Before FERA, it was left to the courts to interpret what constituted an “obligation.”

In FERA, Congress defined an “obligation” to include “an established duty, whether or not fixed, arising from ... the retention of any overpayment.” Improper retention of Medicare or Medicaid overpayments are now within the scope of FCA liability, which has significant implications for providers. It remains to be determined, however, under what circumstances and when retention of overpayments can result in FCA liability. The Senate Judiciary report to the FERA suggests the new provision is not intended to create liability for overpayments “permitted by a statute or regulatory process for reconciliation.”

Impact on Health Care Providers

The FCA expansions are particularly significant in light of the federal government’s increased focus on reducing fraud and abuse in the Medicare and Medicaid entitlement

programs. As discussed in Pepper Hamilton’s November 2008 *Health Care Law Update* (http://www.pepperlaw.com/publications_update.aspx?ArticleKey=1275), the Recovery Audit Contractor (RAC) program has commenced its review of Medicare claims. Providers whose Medicare or Medicaid payments are the subject of RAC or Medicaid Integrity Contractor (MIC) investigation risk additional FCA liability for false or fraudulent statements or claims made in connection with the payments. In addition to the threat of enhanced government scrutiny, hospitals and other providers face of an increasing threat of whistleblower suits brought by vendors, contractors and former employees.

Pending Legislation

H.R. 1788, a second bill pending in the House of Representatives, would further broaden the scope of FCA. Proposed provisions of H.R. 1788 include the expansion of liability to include retained overpayments that are not knowingly received, increased financial penalties, and diminished defenses against *qui tam* claims. Pepper Hamilton’s Health Care Services practice group will continue to monitor the progress of H.R. 1788 and other future FCA developments.

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