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## Table of Contents





# Death By a Thousand Cuts: The Expanding Liability of HIPAA Violations

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As recently as 2007, legal scholars were describing the Health Insurance Portability and Accountability Act (HIPAA) as a "toothless law" struggling from "administrative under-enforcement" and lacking any recognition of private causes of action under common law.[1] Less than a decade later, hospitals, health systems, other covered entities, and their business associates are finding that the environment surrounding HIPAA enforcement has evolved in a way that a single privacy event can result in massive financial exposure from regulatory bodies and private actors.

## Drawing First Blood

In November 2013, the U.S. Department of Health and Human Services (HHS) Office of Inspector General issued a report critical of the HHS Office for Civil Rights' (OCR's) ability to "follow investigation policies and procedures for properly initiating, processing, and closing Security Rule investigations."[2] Afterwards, OCR made a series of public announcements that it would "ramp up" enforcement efforts against providers found to have violated HIPAA's privacy and security rules.[3] OCR has held true to its word.

In 2014, OCR reached a settlement with New York and Presbyterian Hospital (NYP) and Columbia University (CU) over a reported breach that was caused when a lack of technical safeguards resulted in electronic protected health information (ePHI) being publicly accessible on internet search engines.[4] The investigation found that: (1) NYP and CU failed to make efforts prior to the breach to ensure that the server contained appropriate software protections; (2) NYP and CU failed to conduct an accurate and thorough risk analysis; (3) NYP and CU failed to have an adequate risk management plan addressing threats to ePHI; and (4) NYP failed to implement appropriate policies for access to its databases and failed to comply with its own policies on information access management.[5] As a result of the investigation, OCR reached a monetary settlement with NYP for $3.3 million and with CU for $1.5 million, with both entities also agreeing to a substantive corrective action plan.[6]

In 2015, OCR reached a settlement with Triple-S Management Corporation (Triple-S) over purported widespread non-compliance throughout the various Triple-S subsidiaries.[7] OCR determined that Triple-S had: (1) failed to implement appropriate safeguards to protect protected health information (PHI); (2) impermissibly disclosed PHI to an outside vendor with no business associate agreement in place; (3) disclosed PHI more than necessary in mailings; (4) failed to conduct an adequate risk analysis on information technology (IT) systems using ePHI; and (5) failed to implement security measures to reduce the risks of ePHI disclosure.[8] Triple-S entered into a settlement agreement with OCR for $3.5 million and was required to adopt a "robust" corrective action plan.[9]

These settlements—and others[10]—show that OCR has indeed "ramped up" its enforcement efforts, and health care providers now potentially face significant regulatory fines for privacy violations. However, exposure does not end after successfully navigating an OCR investigation. Providers also face a growing focus from the plaintiffs' bar on developing potential HIPAA violations into a new avenue for civil lawsuits.

## Not Just a Flesh Wound

HIPAA does not expressly create a private cause of action.[11] Recently, however, courts have been receptive to plaintiffs' claims under state law causes of action related to an alleged wrongful disclosure of PHI and have declined to rule that such claims are preempted by HIPAA. For example, in West Virginia, a plaintiff filed suit against St. Mary's Medical Center (St. Mary's), asserting a litany of claims[12] after he had been informed of "inappropriate access to his medical record" but was provided no further information.[13] St. Mary's responded with a motion to dismiss for failure to state a claim, asserting that the plaintiff's claims were preempted by HIPAA.[14] While the trial court agreed with St. Mary's, the Supreme Court of Appeals for West Virginia reversed, holding that "common-law tort claims based upon the wrongful disclosure of medical or personal health information are not preempted by [HIPAA]."[15]

Health care providers may be quick to jump to the conclusion that even if courts allow these cases to proceed, no plaintiff will be able to quantify financial damages for a fact-finder to assess. Juries have not necessarily agreed. In a recent case in Indiana, a plaintiff filed suit against Walgreens after one of its pharmacists accessed the plaintiff's PHI and disclosed it to the plaintiff's ex-boyfriend, who also was the pharmacist's husband.[16] The access by the pharmacist was in direct violation of Walgreen's company policy.[17] Walgreens argued, among other things, that it could not be held vicariously liable for the actions of an employee; however, the trial court disagreed and a jury ruled in the plaintiff's favor, finding that the total amount of damages suffered by the plaintiff was $1.8 million, of which Walgreens was 80% responsible.[18]

On appeal, Walgreens asserted that the damages assessed by the jury were unreasonable, arguing that the plaintiff: (1) did not have a physical injury resulting from the breach; (2) had no lost wages as a result of the breach; and (3) did not offer any testimony from a medical professional supporting her claim of emotional distress.[19] Citing the broad discretion of the jury in awarding damages, the appeals court "decline[d] to disturb the damages award."[20]

This may only be the tip of the iceberg. The industry's expanding use of ePHI, coupled with increasing cyber attacks on health providers' IT systems, greatly expand potential liability. A class action lawsuit filed in July 2015 stemming from a cyber attack against UCLA Health System (UCLA Health) alleges UCLA Health failed to take basic precautionary steps to protect the personal and medical information for as many as 4.5 million individuals.[21] If the plaintiff is able to prove a common class and that UCLA Health violated the California Confidentiality of Medical Information Act, every violation would entitle each member of the 4.5 million class to $1,000 in statutory damages, plus an additional $3,000 in punitive damages.[22]

In a similar situation, Premera Blue Cross (Premera) reported a data breach affecting 11 million patients.[23] Hackers allegedly gained access to patient names, addresses, dates of birth, email addresses, telephone numbers, Social Security numbers, member identification numbers, bank account information, and claims information, including personal clinical data.[24] On March 26, 2015, a class action petition was filed alleging Premera knew about its system's inadequacies prior to the breach but did not implement cyber security measures to protect the information and then failed to timely disclose the breach.[25] The class action petition asserts seven claims, including a negligence per se claim that states that Premera had a duty under HIPAA to secure and safeguard PHI and failed to meet that duty.[26] This case has since been consolidated with seven other similarly filed cases.[27] Premera has filed a motion to dismiss.[28] However, if the plaintiffs are successful in surviving dispositive motions and establishing a class inclusive of all affected patients, even a modest settlement would result in significant financial exposure.

## Preventative Care

Health care providers can take steps to minimize the harm of confirmed breaches through appropriate risk analysis; timely notifications; post-incident analysis; corrective measures; and meaningful, ongoing, training to staff and contractors. Compare, for example, the OCR settlement with NYP and CU discussed above and the reported breach by Lawrence Memorial Hospital (Lawrence).[29] In October 2011, Lawrence discovered a technical deficiency in its online bill pay service managed by a business associate, which allowed the PHI of over 8,275 patients to be publicly searchable through internet search engines like Google.[30] Upon discovering the incident, Lawrence conducted a timely risk analysis,

notified the business associate and terminated the relationship, sent the HIPAA-required notifications to affected individuals within two to three weeks of discovery, conducted post incident analysis and policy revisions, and provided additional training to its staff.[31] These remedial measures, taken well in advance of the subsequent OCR investigation, were vital in effectively responding to the OCR's requests for information.[32] Ultimately, OCR closed the investigation and issued no penalties against Lawrence.[33] When compared to the NYP and CU settlement—where there were findings of a failure to conduct a risk analysis, no monitoring of certain IT services, insufficient implementation of security measures, and failure to implement and follow policies—the Lawrence example shows that providers who take prompt remedial measures stand a better chance of avoiding excessive liability.

However, even with appropriate safeguards and robust monitoring and auditing processes, organizations may not be able to fully insulate themselves from liability caused by breaches of PHI or cyber attacks that expose ePHI. Providers should take a hard look at their insurance options and consider adding cyber liability coverage to protect against exposure from hackers and other outside cyber attacks. Furthermore, when faced with a lawsuit from the plaintiffs' bar in HIPAA-related matters, sometimes the best defense is a good . . . *defense*. Organizations should take care to aggressively defend frivolous HIPAA-related private lawsuits as the law in this area continues to develop. Likewise, "if courts are to recognize some right of action under HIPAA" they must be careful to "prevent aggressive plaintiffs from suing providers for technical, benign violations."[34]

1 Joshua D.W. Collins, *Toothless HIPAA: Searching for a Private Right of Action to Remedy Privacy Rule Violations*, 60 Vand. L. Rev. 199, 233 (2007).

2 *The Office for Civil Rights Did Not Meet All Federal Requirements in Its Oversight and Enforcement of the Health Insurance Portability and Accountability Act Security Rule,* Office of Inspector General, Nov. 2013, A-04-11-05025, *available at* http://oig.hhs.gov/oas/reports/region4/41105025.pdf.

3 *See e.g.*, Erin McCann, *OCR to "Ramp Up" HIPAA Enforcement*, Healthcare IT News, April 18, 2014, *available at* www.healthcareitnews.com/news/ocr-ramp-hipaa-enforcement; *see also* e.g., Lynn Sessions, Kimberly Wong, and Cory Fox, *HHS Attorney: Major HIPAA Fines and Enforcement Coming*, Data Privacy Monitor, June 13, 2014, *available at* www.dataprivacymonitor.com/enforcement/hhs-attorney-major-hipaa-fines-and-enforcement-coming/ ("…the past 12 months have seen record-breaking HIPAA enforcement activity by HHS OCR").

4 U.S. Department of Health and Human Services, "Data Breach Results in $4.8 Million HIPAA Settlements," May 7, 2014, *available at* www.hhs.gov/about/news/2014/05/07/data-breach-results-48-million-hipaa-settlements.html#.

5 *Id.*

6 *Id.*

7 U.S. Department of Health and Human Services, "Triple-S Management Corporation Settles HHS Charges by Agreeing to $3.5 Million HIPAA Settlement," Nov. 30, 2015, *available at* www.hhs.gov/about/news/2015/11/30/triple-s-management-corporation-settles-hhs-charges.html.

8 *Id.*

9 *Id.*

10 *See e.g.*, U.S. Department of Health and Human Services, "Physical therapy provider settles violations that it impermissibly disclosed patient information," *available at* www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/complete-pt/index.html; and U.S. Department of Health and Human Services, "HIPAA Settlement Reinforces Lessons for Users of Medical Devices," Nov. 25, 2015, *available at* www.hhs.gov/about/news/2015/11/25/hipaa-settlement-reinforces-lessons-users-medical-devices.html; and U.S. Department of Health and Human Services, "$750,000 HIPAA settlement underscores the need for organization-wide risk analysis," December 14, 2015, *available at* www.hhs.gov/about/news/2015/12/14/750000-hipaa-settlement-underscores-need-for-organization-wide-risk-analysis.html.

11 *See Doe v. Board of Trs. of Univ. of Ill.*, 429 F. Supp. 2d 930, 944 (N.D. Ill. 2006) ("Every court to have considered the issue . . . has concluded that HIPAA does not authorize a private right of action"); *Slue v. New York Univ. Med. Ctr.*, 409 F. Supp. 2d 349, 373 (S.D.N.Y. 2006) ("Federal courts have found that Congress did not intend for HIPAA to create a private cause of action for individuals"); *Valentin Munoz v. Island Fin. Corp.*, 364 F. Supp. 2d 131, 136 (D.P.R. 2005) ("[C]ourts have consistently found that HIPAA does not provide an implied private cause of action").

12 The plaintiff's suit included causes of action for negligence, outrageous conduct, intentional infliction of emotional distress, negligent infliction of emotional distress, negligent entrustment, breach of confidentiality, invasion of privacy, and punitive damages. *R.K. v. St. Mary's Med. Ctr., Inc.*, 735 S.E.2d 715, 718 (2012).

13 *R.K. v. St. Mary's Med. Ctr., Inc.*, 735 S.E.2d 715, 717 (2012).

14 *Id.* at 718.

15 *Id.* at 724. *But see Sheldon v. Kettering Health Network*, 40 N.E.3d 661, 678 appeal not allowed (Ohio Feb. 10, 2016). ("Because we believe allowing such a claim to proceed effectively would allow a private action for damages predicated on HIPAA requirements, recovery based on that part of the complaint is prohibited.")

16 *Walgreen Co. v. Hinchy*, 21 N.E.3d 99, 104 - 105 (Ind. Ct. App. 2014) on reh'g, 25 N.E.3d 748 (Ind. Ct. App. 2015) transfer denied, 29 N.E.3d 1274 (Ind. 2015) and transfer denied, 29 N.E.3d 1274 (Ind. 2015).

17 *Id.* at 105.

18 *Id.* at 106.

19 *Id.* at 113.

20 *Id.*

21 *Allen v. UCLA Health Systems Auxiliary et al,* No. 2:15-cv-05487-ODW-FFM (C.D. Calf. filed Jul. 20, 2015) Dkt. 1, p. 3.

22 Jackson McNeil, "UCLA Faces Class Action Lawsuit Over Health Data Breach," *Law Inc.*, July 22, 2015, *available at* www.lawinc.com/ucla-class-action-lawsuit-health-data-breach.

23 "Five Class Action Lawsuits Filed Against Premera for HIPAA Breach," *HIPAA Journal,* March 30, 2015, *available at* www.hipaajournal.com/5-class-action-lawsuits-filed-against-premera-for-hipaa-breach-812/.

24 *Cossey et al v. Premera Blue Cross,* No. 2:15-cv-00413-RSM (W.D. Wash. filed Mar. 26, 2015) Dkt. 1, p. 3.

25 *Id.*

26 *Id* p. 24.

27 *In Re: Premera Blue Cross Customer Data Security Breach Litigation*, United States Judicial Panel on Multidistrict Litigation, No. 3:15-md-02633-SI (MDL No. 2633, filed Jun. 16, 2015).

28 *Colcord v. Premera Blue Cross*, No. 3:15-cv-00516-SI (D. Ore. filed Mar. 27, 2015) Dkt. 49.

29 Julie Roth and Susan Thomas, "Surviving A Data Breach," Data Privacy and Security Seminar, Lathrop & Gage LLP, Kansas City, Missouri, Aug. 19, 2015 Presentation.

30 *Id.*

31 *Id.*

32 *Id.*

33 *Id.*

34 Collins at 233.

# The Providers Strike Back: The Continued Backlog of Medicare Appeals and the Availability of Injunctive Relief

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## Introduction

Under the Medicare statute, provider challenges to claim denials and audit findings by the Centers for Medicare & Medicaid Services (CMS) are subject to five distinct levels of appeal. During the course of this five-level appeals process, however, the Medicare statute also permits the government to begin recouping the alleged overpayments, even before the provider has a chance to argue its case at a hearing before an Administrative Law Judge (ALJ).

Historically, health care providers have had very little success in challenging the government's pre-hearing recoupment practices. However, in the last few years, the government's new recovery and audit programs have sparked an enormous influx of provider appeals, thereby creating a logjam of appeals at the ALJ level. For this reason, health care providers waiting in line for a hearing often face a much more significant threat of financial hardship than in years past. As a result, health care providers (and their attorneys) have recently renewed their efforts to fight back against CMS' pre-hearing recoupments. In fact, recent challenges in this area provide encouraging results for the health care attorney conducting Medicare appeals in the current backlogged environment.

## The Medicare Claims Appeal Process

### The Basics of a Medicare Audit

Since the inception of the Medicare program, CMS has contracted with various private companies for Medicare claims processing.[1] These private companies, known as Medicare Administrative Contractors (MACs), are assigned to one of 12 geographic regions and are responsible for processing Medicare Part A and Part B claims.[2] Thus, in order to obtain reimbursement for rendering services to a Medicare beneficiary, health care providers must submit claims to their respective MACs.[3]

Once a MAC has made the initial decision to reimburse a claim, that claim may be subsequently audited (reopened) on post-payment review by either the MAC or another kind of CMS contractor. CMS currently works with four other types of audit contractors: Recovery Auditors (formerly known as Recovery Audit Contractors, or RACs),[4] Zone Program Integrity Contractors (ZPICs),[5] Comprehensive Error Rate Testing (CERT) contractors,[6] and Supplemental Medical Review Contractors (SMRCs).[7] Although these various contractors have specific duties unique to the scope of their respective audits, each is ultimately tasked with the same purpose and objective—conducting post-payment reviews aimed at determining the validity of the initial reimbursement decision.[8]

### Appealing the Audit Findings

For providers facing unfavorable initial decisions or post-payment audit findings, the Medicare statute provides a five-level process for appealing unfavorable determinations.[9] The same appeals process applies to pre-payment and post-payment claims disputes, and the same process applies irrespective of the type of Medicare contractor that instituted the pre- or post-payment review.

The first level in the appeals process involves resubmitting the initial claim to the MAC for a redetermination.[10] Once a provider gets an initial determination from the MAC denying payment, or once the MAC's initial payment decision is overturned on post-payment, the provider has 120 days to submit a request to the MAC for redetermination.[11] However, on post-payment reviews at the redetermination level (i.e., where the provider is challenging a contractor's finding that the provider received an overpayment), CMS will begin recouping the money it has determined the provider owes beginning 41 days following the initial overpayment demand.[12] Filing a request for redetermination, however, stays the recoupment pending further review.[13] Thus, in order to avoid recoupment at this stage, the provider must file the redetermination request within 41 days of receiving the initial overpayment demand letter (rather than the 120 days prescribed by statute). The MAC then has 60 days from the date it receives the appeal letter to issue a redetermination decision.[14]

If the MAC's decision remains the same on redetermination, the provider has 180 days to request that a qualified independent contractor (QIC) overturn the MAC's decision.[15] This second level is called a request for reconsideration. As with the first level, if the provider's appeal pertains to an alleged overpayment, CMS will begin recoupment on the 60th day from the *initial* determination, less the period tolled by the level-one request for redetermination.[16] Thus, in order to stay recoupment at this stage, the provider must file its request for reconsideration within 30 days of the MAC's redetermination decision. The QIC must then render its decision within 60 days.[17]

If the QIC upholds the MAC's decision, and the amount-in-controversy threshold (currently $150 with annual fluctuations to account for inflation) is met,[18] the provider may request a hearing before an ALJ within 60 days of receiving

the QIC's adverse decision.[19] This third stage often represents the provider's first opportunity for an impartial hearing. Although ALJs must give "substantial deference" to Local Coverage Determinations (guidance issued by MACs) and other CMS guidance, such policies do not have binding effect,[20] and the ALJ conducts a *de novo* review.[21] Such requests must be filed with the Office of Medicare Hearings and Appeals (OMHA).

With regard to this third stage of the appeals process, two provisions are of particular importance. First, as with the initial stages, the regulations provide an express deadline by which the third stage must be completed; ALJs are required to render their decisions "no later than the end of the 90 calendar day period beginning on the date the request for hearing is received by the entity specified in the QIC's notice of reconsideration," unless an exception applies.[22] Second, and most importantly, CMS may begin recoupment as soon as the QIC renders its reconsideration decision; unlike the redetermination and reconsideration stages, the filing of a request for an ALJ hearing does not stay the recoupment process.[23]

The final two stages of the Medicare claims appeals process are a review of the ALJ's ruling by the Departmental Appeals Board (DAB) of the Medicare Appeals Council (to be filed within 60 days of the ALJ's decision) and judicial review of the DAB's decision in federal court.[24] Unfortunately, due to the significant backlog at OMHA, as well as the current backlog at the DAB level, very few providers obtain the "final decision" necessary to seek judicial review.

### Escalation

Importantly, for each of the stages two through four (reconsideration, ALJ review, and DAB review), the statute and regulations provide for a right of escalation, allowing the provider to move his appeal to the next level if the QIC, ALJ, or DAB is unable to complete its review within the statutory timeframes. If a QIC does not render a decision within 60 days from the date a request for reconsideration was filed, a party can escalate the appeal to an ALJ.[25] Similarly, the provider may bypass the ALJ and go directly to the DAB if the ALJ fails to render an opinion within 90 days (or 180 days if escalated from the QIC).[26] On an appeal escalated past the ALJ stage, the DAB has 180 days to render a decision before a party can seek judicial review.[27]

Unlike the ALJ, however, although the DAB may conduct additional proceedings, such as a hearing, it is not required to do so.[28] Indeed, OMHA has stated that in cases where a provider escalated the appeal to the DAB without getting an ALJ hearing, the DAB will "NOT hold a hearing or conduct oral argument unless there is an extraordinary question of law/policy/fact."[29] For this and other reasons, as demonstrated below, some courts have found that these escalation rights fall short of providing relief to providers seeking to overturn an adverse payment decision.

## Logjam at OMHA

In December 2013, Nancy Griswold, OMHA's Chief ALJ, issued a formal memorandum to all Medicare appellants, informing them that the "average wait time for a hearing before an [ALJ] has risen to 16 months and is expected to continue to increase. . . ."[30] As such, she continued, OMHA would be temporarily suspending assignments of almost all new requests for ALJ hearings and "[did] not expect general assignments to resume for at least 24 months. . . ."[31]

Chief Judge Griswold later explained this moratorium in greater detail while testifying before a subcommittee of the House Oversight & Government Reform Committee. There, Griswold stated that from Fiscal Year (FY) 2011 through FY 2013, OMHA saw a 545% growth in the number of Medicare appeals (from 59,000 in FY 2011 to 384,151 in FY 2013).[32] She attributed this significant rise in the number of appeals to the constantly increasing number of beneficiaries utilizing Medicare-covered services, as well as to "the expansion of OMHA's responsibility to adjudicate appeals resulting from new audit workloads, including the nationwide implementation of the Recovery Audit Program in 2010."[33]

With regard to the creation of the Recovery Audit Program, Chief Judge Griswold was not alone in tying the active audit undertakings of the Recovery Auditors to the substantial influx of Medicare appeals. Because Recovery Auditors' compensation is paid on a contingent basis—increasing with every overpayment uncovered—many others, including the American Hospital Association (AHA) and members of Congress, have acknowledged the correlation between the Recovery Audit Program and the backlog at OMHA.[34]

Yet, despite complaints from providers and trade associations, OMHA's queue remains as crowded as ever. According to the sub-agency's website, for appeals decided in FY 2015, the average processing time was 547.1 days.[35] As of this writing, OMHA currently projects a 20- to 24-week delay in entering new requests into their case processing system.[36]

## Using the Courts to Seek Relief

The ability of CMS to begin recouping overpayments immediately after the reconsideration stage, combined with the unwieldy backlog of ALJ appeals currently pending before OMHA, has caused (and continues to cause) significant financial dilemmas for many health care providers moving through the appeals process. However, two challenges from within the last year, including a potentially landmark decision from the DC Circuit, demonstrate the viability of claims for various forms of injunctive relief.

**Temporary Restraining Order—*Hospice Savannah v. Burwell***

In 2015, Hospice Savannah Inc. (Hospice Savannah), a Georgia hospice provider serving close to 200 terminally ill patients, sought injunctive relief from the U.S. District Court for the Southern District of Georgia in the form of a temporary restraining order (TRO). The provider had undergone a ZPIC audit that, using statistical sampling and extrapolation, had calculated an overpayment of more than $8.6 million.[37] After the ZPIC's audit findings were upheld at both the redetermination and reconsideration stages, Hospice Savannah submitted a request for an ALJ hearing. However, as permitted by the Medicare statute, CMS had already initiated the process of recouping the $8.6 million. Indeed, although Hospice Savannah had submitted a request for ALJ review on September 9, 2015, CMS was scheduled to recoup the first $589,306.04 between September 22-26.[38] Doing so, said Hospice Savannah, would force the hospice provider out of business.[39] Thus, Hospice Savannah's argument was simple: grant a TRO to stay the recoupment process until the ALJ hearing, or risk denying Hospice Savannah its statutory (and potentially constitutional) right to a fair and impartial hearing.

In an order granting the TRO, the district court held that Hospice Savannah had sufficiently demonstrated: (1) a substantial likelihood of success on the merits; (2) that it would suffer irreparable harm without the injunction; (3) that the threatened harm to Hospice Savannah outweighed the potential damage to the government; and (4) that the injunction, if issued, would not be adverse to the public interest.[40] Specifically, Hospice Savannah was able to demonstrate the high likelihood of success at the ALJ level simply by looking to the publicly available statistics; OMHA's website shows that providers receive fully favorable or partially favorable decisions from the ALJ more often than unfavorable ones.[41] Thus, the judge found that "[b]y statute, the ALJ hearing is to occur within 90 days, but an administrative backlog at OMHA will likely preclude Hospice Savannah from receiving its hearing . . . for as long as three to five years."[42]

Ultimately, after the TRO hearing, CMS agreed to settle the case and stay recoupment until after Hospice Savannah had exhausted its administrative appeal rights.[43]

**Mandamus—*AHA v. Burwell***

In 2014, using arguments similar to those in *Hospice Savannah* pertaining to the OMHA backlog and CMS' recouping efforts, the AHA and various hospitals sought injunctive relief in the DC district court.[44] However, instead of asking for the court to stay the recoupment until after the hospitals had exhausted their appeal rights, these providers asked the court for mandamus—in other words, to force OMHA to abide by its statutory mandate and render a decision within the 90-day timeframe. Although unsuccessful at the trial court level, the plaintiffs appealed to the DC Circuit, which agreed with the plaintiffs' stance.[45]

In this case, the court's decision hinged on whether the statutory timeframe within which the ALJ must render a decision constitutes a "mandatory deadline." Noting first that the statute uses the term "shall" and repeatedly calls the timeframes "deadlines," the court addressed the government's argument that Congress' inclusion of the escalation provisions "indicates that Congress anticipated that violations might occur with some measure of regularity."[46] Dismissing this argument, the court stated that "[m]erely providing a consequence for noncompliance does not necessarily undermine the force of a command."[47] Moreover, "[e]scalation from the ALJ stage to the DAB stage is unlikely to provide a timely hearing. Not only does the DAB itself have a backlog, but it holds hearings only where an 'extraordinary question' is involved."[48]

The government also contended that AHA's request for mandamus constitutes a "programmatic attack" on the way the agency manages its resources, and that "even if [the agency] had the necessary resources, [the Court] should hesitate to reorder agency priorities in such a manner."[49] Finding this unpersuasive, the court cited precedent that said that "[h]owever many priorities the agency may have, and however modest its personnel and budgetary resources may be, there is a limit to how long it may use these justifications to excuse inaction in the face of a statutory deadline."[50] The DC Circuit held that the district court had mandamus jurisdiction and, accordingly, reversed the district court's dismissal for lack of jurisdiction.[51] The court ultimately remanded the case for the district court to determine whether "compelling equitable grounds" existed to issue a writ of mandamus.[52]

## Conclusion

The ability of CMS auditors to recover very large amounts of money in alleged overpayments has resulted in a deluge of Medicare claim appeals and has put appealing providers in a precarious position as CMS begins to recoup alleged overpayments before the provider can avail itself of its statutory right to a hearing. Yet, the current backlog at OMHA, which will last for the foreseeable future, puts providers going through the appeals process today in a unique position to fight back, as demonstrated by the recent cases discussed above. Although such challenges are not always fruitful, recent successes suggest that courts may be taking to the argument for injunctive relief.

**We would like to thank Scott R. Grubman (Partner, Chilivis Cochran Larkins & Bever LLP, Atlanta, GA) and Samuel S. Shapiro (Associate, Chilivis Cochran Larkins & Bever LLP, Atlanta, GA) for authoring this article.*

1 42 U.S.C. § 1395kk-1(a); *see also*, Centers for Medicare & Medicaid Services, "Medicare Administrative Contractors," *available at* www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontractors.html (last visited Feb. 27, 2016).

2 *See* CMS, "What is a MAC?" *available at* www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html (last visited Feb. 27, 2016).

3 42 U.S.C. § 1395ff(a)(1)-(2); 42 C.F.R. §§ 405.904(a)(2), 405.920-405.928.

4 Recovery Auditors are private companies tasked with identifying improper payments on a post-payment basis. *See* Government Accountability Office (GAO) Report 13-552, "Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency," GAO Highlights (July 2013), *available at* www.gao.gov/assets/660/656133.pdf.

5 ZPICs are tasked with investigating potential fraud, "which can result in referrals to law enforcement or administrative actions." *See id.*

6 CERT contractors review "a sample of claims nationwide and related documentation to determine a national Medicare FFS [fee-for-service] improper payment rate." *Id.*

7 Currently, CMS has contracted with only one SMRC: StrategicHealth-Solutions LLC. *See* www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html (last visited Feb. 27, 2016); www.strategichs.com/about-smrc (last visited Feb. 27, 2016). The SMRC is tasked by CMS to perform medical review activities and "to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs." Medicare Program Integrity Manual, Ch. 1, Sec. 1.3.1(D).

8 *See* GAO Report 13-552, *supra* note 4.

9 42 U.S.C. § 1395ff et seq.; 42 C.F.R. § 405.900 et seq.; *but see* 42 C.F.R. § 498.5 (outlining different set of appeal rights for adverse actions taken against the provider's Medicare contract, such as termination, exclusion, or suspension).

10 42 U.S.C. § 1395ff(a)(3)(A); 42 C.F.R. § 405.904(a)(2).

11 42 U.S.C. § 1395ff(a)(3)(C)(i); 42 C.F.R. § 405.950; MCPM (CMS Pub. 100-04), Ch. 29, § 310.4, *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf.

12 42 C.F.R. § 405.379(d)(1).

13 *Id.* ("Medicare contractors can begin recoupment no earlier than 41 days from the date of the initial overpayment demand but shall cease recoupment of the overpayment in question, upon receipt of a timely and valid request for a redetermination of an overpayment. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment.").

14 42 C.F.R. § 405.950. However, at the redetermination level, the provider has no right to escalate the appeal if the MAC takes longer than 60 days, which is often the case.

15 42 C.F.R. § 405.962(a).

16 42 C.F.R. § 405.379(e)(1)(ii).

17 42 C.F.R. § 405.970.

18 42 C.F.R. § 405.1006(b); *see also*, *id.* at § 405.1006(e) (noting that claims can be aggregated to meet the amount-in-controversy threshold).

19 42 C.F.R. § 405.1002(a).

20 *See* 42 C.F.R. § 405.1062 ("If an ALJ . . . declines to follow a policy in a particular case, the ALJ . . . decision must explain the reasons why the policy was not followed").

21 42 C.F.R. § 405.1000(d).

22 42 C.F.R. § 405.1016(a). The 90-day requirement may be tolled only if: (1) the ALJ grants the provider an extension of the deadline by which to file a request for a hearing; or (2) either the government or the provider requests discovery under § 405.1037. *Id.* at § 405.1016(b)-(d).

23 42 C.F.R. § 405.379(f).

24 42 U.S.C. § 1395ff(b)(1); 42 C.F.R. § 405.1100 et seq.; MCPM (CMS Pub. 100-04), Ch. 29, § 340, *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf.

25 42 U.S.C. § 1395ff(c)(3)(C)(ii); *see also*, 42 C.F.R. §§ 405.970(c)(2) and 405.1016(c) (providing the ALJ with 180 days to render a decision when the appeal comes by way of escalation); MCPM (CMS Pub. 100-04), Ch. 29 *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf.

26 42 U.S.C. § 1395ff(d)(3)(A); *see also*, 42 C.F.R. § 405.1108; MCPM (CMS Pub. 100-04), Ch. 29, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf; 42 C.F.R. § 405.1132.

27 *See* 42 C.F.R. §§ 405.1100(d) and 405.1132.

28 42 C.F.R. § 405.1108.

29 OMHA Medicare Appellant Forum Presentation (Feb. 12, 2014), *available at* www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/omha_medicare_appellant_forum_presentations.pdf.

30 Memorandum to OMHA Medicare Appellants (Dec. 24, 2013), *available at* www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/letter_to_medicare_appellants_from_the_calj.pdf.

31 *Id.*

32 Statement of Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals, on "Office of Medicare Hearings and Appeals Workloads," before the U.S. House Committee on Oversight & Government Reform Subcommittee on Energy Policy, Heath Care & Entitlements (July 10, 2014), *available at* https://oversight.house.gov/wp-content/uploads/2014/07/CMS-Griswold-OMHA-Final.pdf.

33 *Id.*

34 *See, e.g.*, Statement of the American Hospital Association before the Committee on Finance of the U.S. Senate, "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare" (May 15, 2015), *available at* www.aha.org/advocacy-issues/testimony/2015/150513-statement-ad-medicare.pdf.

35 HHS Office of Medicare Hearings and Appeals, *available at* www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html (last visited Feb. 27, 2016).

36 *Id.*

37 *Hospice Savannah, Inc. v. Burwell*, 2015 WL 8488432, *1 (S.D. Ga. 2015).

38 *See Hospice Savannah, Inc. v. Burwell*, "Memorandum of Law in Support of Plaintiff's Motion for Temporary Restraining Order," Case No. 4:15-CV-00253 (Sept. 20, 2015).

39 *Id.*

40 *Hospice Savannah, Inc. v. Burwell,* 2015 WL 8488432, *1 (S.D. Ga. 2015).

41 HHS Office of Medicare Hearings and Appeals, *available at* www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html (last visited Feb. 27, 2016).

42 *Id.*

43 *See* National Association for Home Care & Hospice, "Hospice Obtains Restraining Order Against CMS for Medicare Administrative Appeal Backlog," (Nov. 13, 2015), *available at* www.nahc.org/NAHCReport/nr151113_2/?print=y.

44 *American Hosp. Ass'n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014).

45 *American Hosp. Ass'n v. Burwell*, 2016 WL 491658 (D.C. Cir. Feb. 9, 2016).

46 *Id.* at *7.

47 *Id.*

48 *Id.*

49 *Id.*

50 *Id.* at *8.

51 *Id.*

52 *Id.*

# The Continuing War Between Commercial Insurers and Out-of-Network Providers: Recent and Upcoming Battles Over Waiving Patient Co-Pays

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Over the last decade or more, commercial insurers and out-of-network providers have waged a war in courts across the country over insurers' reimbursement and contracting and providers' patient billing and collection practices. Several current battles in this multi-front war center on providers' discounts of patient co-payments, co-insurance, and deductibles (collectively, patient cost-sharing). While these battles primarily pit ambulatory surgery centers, specialty hospitals, and laboratories against insurers, their outcomes carry important implications for all providers and insurers.

At the heart of the fight over waiving patient cost-sharing lies a crucial question for insurers and providers alike: when is it fraudulent for a provider to waive the out-of-network cost-sharing for a patient covered under a commercial insurance plan? Despite ongoing litigation over the practice, very few courts have actually spoken to this specific question.[1] Recently, several courts have analyzed insurers' allegations of fraud with varying levels of skepticism, and rulings anticipated in a handful of cases may significantly alter the legal landscape with respect to this question.

## The Basis of Insurers' Allegations of Fraud

Insurers argue that out-of-network providers are misrepresenting their charges when they submit charges that do not reflect the discount provided to the patient in the form of waived cost-sharing. Since the insurers rely on these charges in paying the providers—so the argument goes—the providers have fraudulently obtained increased reimbursement from the insurers.

Support for this theory primarily comes from a 1994 special fraud alert issued by the U.S. Department of Health and Human Services Office of Inspector General (OIG) condemning the practice of waiving Medicare cost-sharing amounts for charge-based providers (those paid a percentage of charges),[2] and opinions issued by a handful of state regulators finding that an undisclosed practice of regularly waiving patient cost-sharing could constitute insurance fraud.[3] The explanation for how this practice potentially misrepresents a provider's charges is best illustrated by OIG's example: Consider a physician that treats a patient and submits a bill to Medicare for $100. Medicare Part B typically reimburses physicians 80% of the lesser of the physician's charges or the fee schedule amount, meaning the patient is responsible for the remaining 20%. As explained by OIG, a physician "who routinely waives Medicare copayments or deductibles is misstating its actual charge" because the physician only intends to collect $80 ($100 less the 20% beneficiary co-insurance).[4] Medicare therefore may have paid more than it should have, as the physician is only entitled to collect, at most, 80% of $80 ($64)—not 80% of $100 ($80).

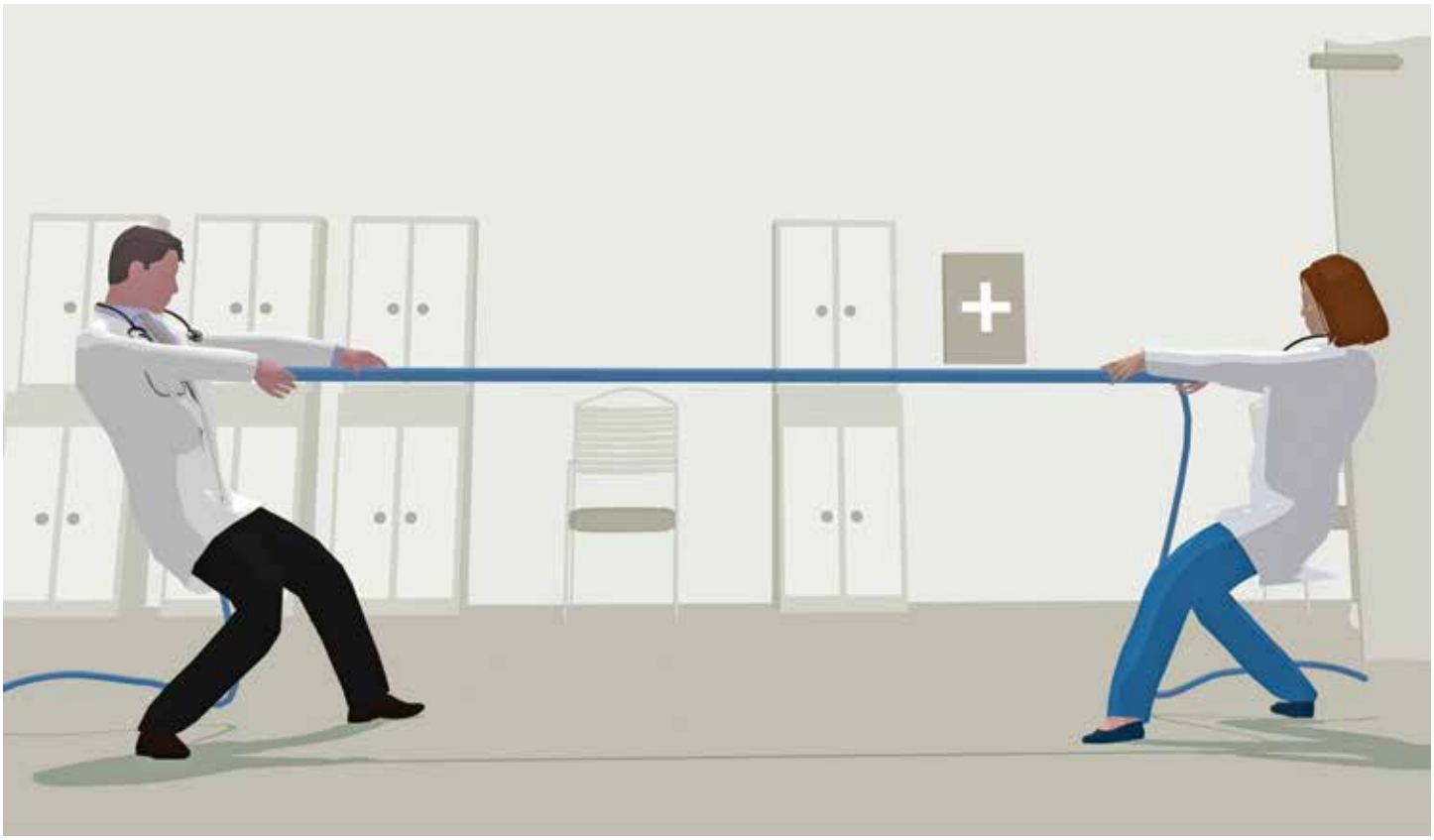
## Establishing the Nature of the Misrepresentation in the Commercial Context

Turning to the commercial insurance world, insurers such as Aetna and Cigna have alleged that out-of-network providers who fail to disclose patient cost-sharing discounts have engaged in common law fraud based on fact patterns similar to the Medicare example described above.[5] A core question in these cases is whether the fraud theory applies to claims submitted by out-of-network providers to commercial insurers in the same way as claims submitted to Medicare.[6]

Unlike in the Medicare context where providers must comply with Medicare rules in submitting claims (including reporting of "actual charges" on the claim), out-of-network providers arguably are not bound by the rules or requirements of commercial insurers to whom they submit claims. Since there also is no representation on the claims form itself that charges are a provider's "actual" or "usual and customary" charges, an open question remains as to the nature of the provider's misrepresentation.[7] Nevertheless, in adjudicating motions to dismiss, judges have predominantly found that the insurers adequately pleaded the elements of fraud or negligent misrepresentation based on allegations that an out-of-network provider waived patient cost-sharing.[8]

A September 2015 decision on the parties' motions for summary judgment could indicate that the fraud theory will be viewed more skeptically when these cases move beyond the pleading stage. In that decision, Judge Yohn in the Eastern District of Pennsylvania distinguished between the charges a provider reports to Medicare and the charges providers include on UB-04 or CMS-1500 claims forms submitted to commercial insurers.[9] He concluded that, while providers represented the charges reported to Medicare as their "actual charges," the charges submitted to Aetna were something else:

> These rates are not "actual charges" that providers intend to collect in full from insurers and members; they are (usually) the inflated "sticker prices" for providers' services that the insurer itself then trims to set the allowed amount.[10]



Not long after granting the surgery center's motion for summary judgment on the insurer's fraud and misrepresentation claims, Judge Yohn retired from the bench and the case was transferred to a different judge. In January 2016, the newly assigned judge denied Aetna's motion to reconsider the decision, but certified the underlying legal questions for interlocutory appeal to the Third Circuit as issues of first impression.

Several other courts are poised to issue decisions on this specific question as well. In the Southern District of Texas, a bench trial in a case brought by Cigna against Humble Surgical Hospital was completed as of February 2, 2016, and the parties await the judge's final decision.[11] Furthermore, in another jurisdiction, a trial was scheduled to begin on March 14, 2016 in an action in California state court.[12] And, in yet two more courts, in *Aetna Health, Inc. v. Patient Care Associates, LLC*, in the District of New Jersey, and *Connecticut General Life Insurance Company, et al. v. Southwest Surgery Center, LLC*, in the Northern District of Illinois, discovery was scheduled to be completed in April 2016.[13]

### Establishing Reliance on Reported Charges

Another open question in many of the cases is whether the insurer actually relied on the provider's reported charges in adjudicating the claim, particularly where the insurer pays claims based on a percentage of the "maximum allowed charge" or "allowable amount," rather than a provider's specific charges. Even where an insurer reimburses at the lesser of the provider's charges or the allowable amount, if a provider's charges, as adjusted to take into account the discount granted, remain above this maximum charge, it may be that the provider's disclosure (or lack thereof) does not affect the payment made by the insurer.

As with the arguments around the basis for the misrepresentation claims, at the motion to dismiss stage, courts have accepted as true insurers' allegations that they relied upon the charges submitted by providers in paying and adjudicating claims.[14] These arguments are likely to be analyzed in further detail in upcoming summary judgment and trial decisions.

### Defending Against Fraud Allegations by Disclosing Discounts

A dispute between Cigna and ambulatory surgery centers around the country managed by SurgCenter Development is requiring courts to analyze whether certain disclosures will insulate the provider from allegations of fraud or misrepresentation. Cigna has filed actions against SurgCenter centers in federal court in Maryland and Indiana,[15] while SurgCenter centers have filed their own actions against Cigna in Arkansas and Colorado.[16] In each case, Cigna has made fraud or misrepresentation claims or counter-claims based on the centers' waivers of patient cost-sharing.

In a twist on the classic fact pattern described above, Cigna has alleged that the centers included a notice to Cigna with the claims it submitted that informed Cigna that the patient's cost-sharing was discounted. In its decision in March 2015, a judge in the District of Colorado held that disclosures made by the centers to Cigna made any allegations of a misrepresentation "implausible":

> In admitting that the ASCs disclosed that they reduced the patient's portion of the bill and made the patient responsible for only an in-network deductible and co-pay amount, Cigna concedes that it was provided information from which it should have known that the ASCs were reducing the amount billed to patients and that they were attempting to approximate in-network rates. Given this disclosure, which appeared in the ASCs' claim forms, the Court finds it implausible that Cigna was misled into believing that the patient was charged the same amount that the ASCs billed to Cigna, because Cigna was aware that the ASCs' claims were higher than in-network rates.[17]

On the other hand, a judge in the District of Maryland found that Cigna had pleaded a misrepresentation claim despite the disclosure from the centers:

> The Cigna entities have plausibly alleged a misrepresentation based on the ASCs' statement used in the claim forms that "[t]he insured's portion of this bill has been reduced," because this statement, without any further qualification, indicates that the insured's billed amount was the same as the amount billed to the Cigna entities, when in fact the Cigna entities allege that it was a different amount entirely.[18]

Litigation between SurgCenter and Cigna is ongoing in at least four different forums, with similar facts alleged in each of the cases. The case in the District of Colorado is scheduled for a 13-day jury trial beginning in July 2016.

## Conclusion

Given the number of currently pending cases and the apparent determination of the parties to obtain decisions on the merits in those cases, several different courts will likely soon issue decisions addressing the underlying question of when it is fraudulent for a provider to waive out-of-network cost-sharing for commercially insured patients. Providers and insurers should keep an eye on these decisions, as they could bring significant clarity to a long-murky area of law.

1 The few cases to address this question prior to the ongoing litigation discussed herein include *OSF Healthcare Sys. v. Banno*, No. 08-1096, 2008 WL 5170628, at *3-4 (C.D. Ill. Dec. 10, 2008) (finding that complaint failed "to specifically allege how or why [the surgery center] had a legal duty to [payor] to charge and/or collect co-payments from . . . [or] exactly what fraud was perpetrated on [the payor]"); *Garcia v. Health Net of N.J., Inc.*, No. C-37-06, 2007 WL 5253484 (N.J. Super. Ct. Ch. Div. Nov. 20, 2007) ("I find no authority to establish that the doctors or the Center acted unlawfully in routinely failing to enforce the obligation of Health Net subscribers to pay co-insurance."), aff'd No. A-2430-07T3, 2009 WL 3849685 (N.J. Super. Ct. App. Div. Nov. 17, 2009); and *People v. Brigham*, 702 N.Y.S.2d 119, 125 (App. Div. 1999) ("Thus, defendant's practice in openly charging these higher, nondiscounted rates to insurance companies did not constitute a misrepresentation of his actual charges for services rendered or an 'overcharge' for services rendered.").

2 *See* OIG: Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374-75 (Dec. 19, 1994), also *available at* https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

3 In 1995, the South Carolina Attorney General concluded that a provider might be violating South Carolina law if the provider included cost-sharing amounts in its disclosed "usual and customary" charges while actually waiving those charges. S.C. Att'y Gen., Informal Op. (Aug. 14, 1995), *available at* www.scag.gov/wp-content/uploads/2013/12/95aug14davis.pdf. A 2005 New York opinion from the Office of the General Counsel for the insurance department similarly concluded that a provider might be guilty of insurance fraud if he or she engaged in a regular practice of waiving co-payments and thus misrepresented his or her usual and customary charges. N.Y. Ins. Dep't, Gen. Counsel Op. No. 05-04-07 (Apr. 8, 2005), *available at* www.dfs.ny.gov/insurance/ogco2005/rg050407.htm. Finally, a December 2005 letter from the Texas Department of Insurance warned that "waiver of patient responsibility for any applicable cost-sharing obligations under an insurance policy may create several problematic issues for the health care provider," and warned of, among other things, allegations of fraud for failure to disclose waivers.

4 59 Fed. Reg. at 65373.

5 *See, e.g., Aetna Health, Inc. et al. v. Patient Care Assocs., LLC et al.*, No. 13 Civ. 3185, Compl. ¶¶ 70-76 (D.N.J. filed May 20, 2013); *Conn. Gen. Life Ins. Co. v. Roseland Ambulatory Ctr.*, No. 12 Civ. 5941, Am. Compl. ¶¶ 49-57 (D.N.J. filed Dec. 7, 2012).

6 Most of these cases have included substantial motion practice on ancillary issues, leading to several significant decisions on such issues, particularly with respect to the Employee Retirement Income Security Act of 1974. This article is limited to discussing decisions regarding the underlying fraud theory.

7 The analysis discussed in these cases may be different in states that have laws explicitly regulating waiver of co-payments or the reporting of charges. *See, e.g.*, Colo. Rev. Stat. § 18-13-119(3)(b); Fla. Stat. Ann. § 817.234(7)(a).

8 *See Conn. Gen. Life Ins. Co v. Southwest Surgery Ctr., LLC*, No. 14 Civ. 8777, 2015 WL 6560536, at *6 (N.D. Ill. Oct. 29, 2015); *Conn. Gen. Life Ins. Co. v. Tex. Spine and Joint Hosp.*, No. 6:14 Civ. 765, Dkt. No. 22 (E.D. Tex. Sept. 10, 2015); *Conn. Gen. Life Ins. Co v. True View Surgery Center One, LP*, 2015 WL 5122269, at *9 (D. Conn. Aug. 31, 2015); *Connecticut Gen. Life Ins. Co. v. Roseland Ambulatory Ctr.* LLC, No. 2:12-CV-05941 DMC, 2013 WL 5354216, at *6 (D.N.J. Sept. 24, 2013).

9 *See Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, No. 13 Civ. No. 3101, 2015 WL 5439223, at *11 (E.D. Pa. Sept. 15, 2015).

10 *Id.*

11 *Conn. Gen. Life Ins. Co v. Humble Surgical Hosp.*, No. 13 Civ. 3291 (S.D. Tex.).

12 *See Aetna Life Ins. Co. v. Bay Area Surgical Mgmt., LLC, et al.*, No. 1-12-cv-217943 (Cal. Sup. Ct. Santa Clara Cnty filed Feb. 2, 2012).

13 *Aetna Health, Inc. et al. v. Patient Care Assocs., LLC et al.*, No. 13 Civ. 3185 (D.N.J.); *Conn. Gen. Life Ins. Co v. Southwest Surgery Ctr., LLC*, No. 14 Civ. 8777 (N.D. Ill.).

14 *See, e.g., True View Surgery Ctr.*, 2015 WL 5122269 at *8 (holding that Cigna's admission that it reimbursed at a "maximum reasonable charge" was irrelevant because "the fraud alleged is that the surgical centers billed Cigna an amount greater than the value they placed on their services"); *Bay Area Surgical Mgmt.*, No. 1-12-cv-217943, Order dated Oct. 1., 2012 (rejecting arguments that Aetna relied on a maximum "recognized charge" by noting that the complaint does not establish the maximum charge was used in all claims).

15 *Conn. Gen. Life Ins. Co. v. Advanced Surgery Ctr. of Bethesda, LLC*, No. 14 Civ. 2376 (D. Md.); *Conn. Gen. Life Ins. Co., et al. v. Northwest Regional Surgery Ctr., LLC, et al.*, 15 Civ. 253 (N.D. Ind.).

16 *Arapahoe Surgery Ctr., LLC v. Cigna Healthcare, Inc.*, No. 13 Civ. 3422 (D. Col.); *Tri State Advanced Surgery Ctr., LLC, et al. v. Health Choice, LLC, et al.*, No. 14 Civ. 143 (E.D. Ark.).

17 *Arapahoe Surgery Ctr.*, No. 13 Civ. 3422, Dkt. No. 80, at pp. 11-12 (Mar. 6, 2015).

18 *Advanced Surgery Ctr. of Bethesda*, 2015 WL 4394408 at *21. *See also TriState Advanced Surgery Ctr.*, No. 14 Civ. 143, Dkt. 92, at pp. 10-11 ("For purposes of surviving a motion to dismiss for failure to state a claim, the Court finds that the limited disclosures contained on the claim forms regarding a reduction in the insured's portion of the bill do not make the alleged fraud claims are implausible.").

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# How (Not) to Get Sued for Disability Discrimination

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## Introduction

Hospitals and health care facilities face significant risks when language access services are not used—or not used properly—to ensure effective communication with Limited English Proficient (LEP), deaf, and hard-of-hearing patients and their caregivers. From medical malpractice and disability discrimination claims to readmissions and basic lack of patient satisfaction, it is important for health care attorneys and compliance professionals to understand the legal obligations their clients have toward the LEP, deaf, and hard-of-hearing communities.[1]

## Key Disability Discrimination Cases in 2015

In 2015, five court decisions provided valuable insights into health care facilities' legal duties under the Americans with Disabilities Act. From these decisions come valuable lessons on how *not* to get sued for disability discrimination.

### *Collins v. Dartmouth-Hitchcock Medical Center, et al*

The first 2015 decision was *Collins v. Dartmouth-Hitchcock Medical Center, et al*, 2015 U.S. Dist. LEXIS 6709 (D.N.H. Jan. 21, 2015). In this case, the patient suffered a hearing loss as a child, becoming profoundly deaf over time, and receiving a cochlear implant.[2] She had visited Dartmouth-Hitchcock Medical Center (DHMC) providers since 1967 and had always communicated via lip reading and the limited hearing provided by her implant.[3] When her implant began to fail, Dr. Saunders recommended surgery to replace it, and the patient agreed.[4]

The patient had never requested an American Sign Language (ASL) interpreter, and her doctor did not know that she understood ASL.[5] Post-surgery, Dr. Saunders first spoke with the patient's sisters, explaining that he had found a growth, removed it, and could not put in a new implant until the patient healed. He explained he had to remove all of the growth, or it could grow back and possibly kill the patient.[6] Dr. Saunders next spoke with the patient, who was groggy from anesthesia, completely deaf without her implant, and not wearing her glasses. Dr. Saunders wrote his messages in large lettering, while also voicing his report (since the patient could read lips).[7] Several hours later, he returned and repeated the note-writing and voice process.[8]

The day before the follow-up appointment, the patient's sister called to request an ASL interpreter, which was provided. The second surgery then was performed, and limited hearing was restored. A year later, when scheduling another appointment, the patient was asked if she needed an interpreter. She said no because her sister would be with her.[9] When the patient arrived for her appointment, without her sister, she asked for an interpreter. The hospital tried to get one, but no interpreter was available. As such, the hospital offered video remote interpreting (VRI).[10] The patient was asked to sign a document consenting to VRI instead of on-site interpreting.[11]

Notably, nothing bad happened to the patient. Her growth was removed, and her new implant worked. Still, she and her sisters sued DHMC and Dr. Saunders, claiming that the patient was refused an interpreter and retaliated against by being forced to waive her right to an on-site interpreter during the VRI appointment. The court ultimately granted summary judgment in favor of the defendants. On the first claim, namely that DHMC and Dr. Saunders should have known to provide an interpreter for the post-surgery meetings, the court pointed out that DHMC and Dr. Saunders did not even know that the patient understood ASL, that she never requested an interpreter previously, and that she did not request an interpreter at that time.[12] The court noted, "[u]nless the need for accommodation is obvious, the requirement for reasonable accommodation usually does not arise unless an accommodation is requested."[13] Additionally, the court explained that Dr. Saunders is well-versed in hearing loss, the treatment of hearing loss, and working with deaf patients. "By training, experience, and interest, Dr. Saunders is aware of the communication barriers experienced by those with hearing impairment."[14] His choice to communicate via voice/lip reading and large-print written word was an appropriate accommodation.[15]

The patient also claimed that DHMC and Dr. Saunders retaliated against her by forcing her to consent to VRI over an on-site ASL interpreter. She likened this request to a "threat" to withhold medical treatment unless she waived her "right" to an on-site ASL interpreter.[16] The evidence, however, did not support the patient's allegations concerning retaliation, particularly because the patient had declined an on-site ASL interpreter during scheduling, having changed her mind after arriving. Plus, there was no evidence that she was "forced" to sign the consent.[17]

Although the hospital and surgeon were ultimately victorious in this case, the facts and decision remain instructive. The decision came after four years of litigation, including document discovery, numerous depositions, and lengthy briefs, despite the fact that there was no physical injury to the patient. Consider how this case would have changed had someone simply asked the patient, before her surgery, if she needed an interpreter, or followed Joint Commission/U.S. Department of Health and Human Services guidelines that restrict (almost to the point of prohibiting) the use of family members as interpreters.

#### *Saunders v. Mayo Clinic*

In *Saunders*,[18] the plaintiff repeatedly complained to the Mayo Clinic that she was unable to understand or be understood by the ASL interpreter.[19] Evidence revealed numerous similar complaints against the interpreter and negative evaluation forms citing similar issues.[20]

When litigation ensued, the Mayo Clinic moved for summary judgment, which the court denied. The court reasoned that the continued use of an interpreter with multiple complaints on record and poor quality assessment scores creates a triable issue of fact as to whether the Mayo Clinic provided reasonable accommodations to the plaintiff.[21]

The lesson learned in *Saunders* is a simple one: quality matters in interpreting. Simply being able to sign (or speak another language) does not make one a *medical* interpreter. Medical interpreters must know medical terminology in at least two languages to effectively facilitate communication, and they require education, training and experience, and appropriate language proficiency assessments.[22]

#### *Shaika v. Gnaden Huetten Memorial Hospital*

One of the more emotional decisions of 2015 was *Shaika v. Gnaden Huetten Memorial Hospital*.[23] In this case, the deaf plaintiff's daughter was rushed to the hospital following an accident, but did not survive. When the plaintiff arrived, a nurse handed her a note that said, "Your daughter is dead," with no other explanation.[24] The hospital's VRI system was malfunctioning, and no interpreter was contacted to provide additional information.[25]

The plaintiff later sued on several grounds, including the "refusal" of an interpreter and negligent infliction of emotional distress. The plaintiff's Title III Americans with Disabilities Act (ADA) and state-law equivalent, negligent infliction of emotional distress, and Section 504 Rehabilitation Act Injunctive and Declaratory relief claims were all dismissed, primarily based on the fact that the hospital had replaced its malfunctioning VRI system, virtually eliminating the likelihood of repeat issues.[26] The court, however, allowed the Section 504 Rehabilitation Act claim for damages to proceed, allowing discovery as to whether the hospital was deliberately indifferent to the plaintiff's rights as a disabled person when it failed to provide an interpreter to explain the circumstances surrounding her daughter's death.

The hospital achieved positive results on many of the plaintiff's claims. However, the court left open the possibility of monetary damages stemming from what was, by all accounts, a callous way to communicate the death of her daughter. Even in a written note, compassion could have been accomplished. While no law requires "compassionate communication," common sense dictates that compassion helps minimize the risk of litigation.

#### *Martin v. Halifax Healthcare Systems, et al.*

In one of the best written decisions on the subject of ASL interpreting issued in 2015 (at least, in this author's opinion), the court in *Martin v. Halifax Healthcare Systems, et al.*[27] provided guidance on whether a deaf patient has a "right" to 24/7, on-site ASL interpreting services. In this case, three deaf plaintiffs all requested or insisted on live, on-site ASL

interpreters.[28] The hospital did not provide continuous live interpreting services to two of the plaintiffs, and no interpreting service at all to the third, instead relying primarily on note writing for communication.[29]

Litigation ensued, and the trial court granted summary judgment to the defendants, and the Eleventh Circuit affirmed. The court noted that the question to be answered was "whether the hospital [violated the ADA] by failing to provide a live ASL interpreter every time an interpreter was requested."[30] Answering in the negative, the court found that, for each plaintiff's case, the exchange of written notes resulted in actual, effective communication.[31] While noting that a live ASL interpreter might be necessary in some situations, the "fact-intensive" inquiry must be based on context, "especially the nature, significance and complexity of the involved treatment."[32] Thus, denying a request for accommodation does not automatically result in a viable claim under the ADA. "Otherwise, a requested service would automatically be transformed into a 'necessary' service merely by the fact it was requested."[33]

It is noteworthy that this litigation stemmed from hospital visits in the summer of 2011. The Eleventh Circuit's decision was issued in the summer of 2015. Though the outcome was positive for the hospital, it took four years of protracted litigation to get there. This is a prime example of "even when you win, you lose."

### *Perez v. Doctors Hospital at Renaissance, Ltd.*

2015 wrapped up with two decisions addressing the use of VRI. In *Perez v. Doctors Hospital at Renaissance, Ltd.*,[34] deaf parents of a young daughter going through two rounds of chemotherapy sued after repeated problems with the hospital's VRI.[35] In discovery, the hospital's Executive Vice President for Nursing admitted that the hospital's ADA compliance policy was "certainly" in need of revision, and the hospital lacked training on addressing the needs of the deaf/hearing impaired.[36]

The Fifth Circuit overruled summary judgment in favor of the hospital, relying primarily on three facts: (1) several requests for interpreting services were outright denied; (2) the hospital failed to revise its ADA compliance policy as well as failed to provide training; and (3) the VRI system was "often ineffective."[37] Notably, the court found that "even without applying a deliberate indifference standard," there was a fact issue as to whether the hospital intentionally discriminated against the plaintiffs.[38]

### *Silva v. Baptist Health South Florida, Inc.*

*Perez* stands in contrast to *Silva v. Baptist Health South Florida, Inc.*[39] In *Silva*, two plaintiffs requested live interpreters, but were instead provided with VRI.[40] In their complaint, the allegations were general and vague, e.g., "I was unable to understand most of what the hospital staff attempted to communicate."[41] The complaint also included many conclusory and speculative statements, such as "I could receive the wrong medical treatment."[42] No evidence was cited of a likelihood of recurrence, other than the plaintiff's preference to use the hospital for reasons of convenience.[43] Finally, the hospital presented substantial evidence of up-to-date VRI equipment, well-staffed VRI, routine maintenance, routine upgrades, and ample Internet bandwidth.[44]

Despite evidence of occasional glitches with the VRI system, the court found that the VRI system provided effective communication.[45] The court focused heavily on the hospital's ample evidence that it took care of its VRI system. Additionally, the court noted that the plaintiffs failed to plead real "facts," instead relying on generalities and conclusory statements, which failed to overcome the hospital's record, including "robust clinical reports" demonstrating effective communication.[46]

Frequently recurring themes in litigation by deaf plaintiffs against hospitals include "the VRI system didn't work," and "no one knew how to use the VRI system." As we see in *Perez*, when this is true, the outcome is often unfavorable for the hospital. However, when the facility has an effective VRI system and staff knows how to use it, as in *Silva*, the outcome is most often favorable, especially when patient records demonstrate the level of detail medical staff are able to generate using VRI.

## Conclusion

2015 saw fairly significant court attention to health care facilities' duty to accommodate deaf and hard-of-hearing patients under the ADA. From these decisions, a few key lessons can be learned: (1) using written notes, lip reading,

or friends/family as interpreters can be found by courts to be appropriate under the ADA, but they may well get you sued; (2) if you are going to rely on VRI, make sure it works and staff are trained on how/when to use it; and (3) compassion counts—no matter how the patient communicates.

1 For a comprehensive look at Language Access Compliance, the author recommends the U.S. Department of Health and Human Services "Think Cultural Health" website, *available at* www.thinkculturalhealth.hhs.gov/, and, specifically, the *Guide to Providing Effective Communication and Language Assistance Services, available at* www.thinkculturalhealth.hhs.gov/Content/communication_tools.asp.
2 *Collins v. Dartmouth-Hitchcock Medical Center*, 2015 U.S. Dist. LEXIS 6709 at *1 (D.N.H. Jan. 21, 2015).
3 *Id.* at *2.
4 *Id.*
5 *Id.*
6 *Id.* at *4-5.
7 *Id.* at *6-7.
8 *Id.* at *8.
9 *Id.* at *8-9.
10 *Id.* at *9.
11 *Id.* at *20.
12 *Id.* at *14.
13 *Id.* at *13, *citing, Kiman v. N.H. Dep't of Corrs.*, 451 F.3d 274, 283 (1st Cir. 2006).
14 *Id.* at *13.
15 *Id.* at *14.
16 *Id.* at *19-20.
17 *Id.*
18 *Saunders v. Mayo Clinic*, 2015 U.S. Dist. LEXIS 21824 (D. Minn. Feb. 24, 2015).
19 *Id.* at *11.
20 *Id.*
21 *Id.* at *12-13.
22 *See, e.g.*, Joint Commission Standard HR.01.02.01, EP1, Note 4.
23 *Shaika v. Gnaden Huetten Memorial Hospital*, 2015 U.S. Dist. LEXIS 87478 (M.D. Penn. July 7, 2015).
24 *Id.* at *1-3.
25 *Id.* at *2.
26 *Id.* at *17.
27 *Martin v. Halifax Healthcare Systems, et al.*, 621 Fed. Appx. 594, 2015 U.S. App. LEXIS 13383 (11th Cir. 2015).
28 *Id.* at 596.
29 *Id.*
30 *Id.* at 601.
31 *Id.* at 603.
32 *Id.*, *citing*, 28 C.F.R. §36.303.
33 *Id.*
34 2015 U.S. App. LEXIS 15351 (5th Cir. Aug. 28, 2015).
35 *Id.* at *2-3.
36 *Id.* at *7-8; *10.
37 *Id.* at *8, *12.
38 *Id.* at *12.
39 2015 U.S. Dist. LEXIS 143074 (S.D. Fla. Oct. 9, 2015).
40 *Id.* at *2-3.
41 *Id.* at *13-14.
42 *Id.* at *5.
43 *Id.* at *53-54.
44 *Id.* at *10-12.
45 *Id.* at *11.
46 *Id.* at *14, *18-19, *26-27, and *29-30.

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# In-House Counsel Program and Annual Meeting

**JUNE 26-29, 2016 • Sheraton Denver Downtown Hotel**

**DENVER**

## An OCR Enforcement Update—Learning From the Past and Preparing for the Future

June 29, 12:00-1:15 pm

*This luncheon is brought to you by the Health Care Liability and Litigation and Health Information and Technology Practice Groups and the Enterprise Risk Management Task Force.*

The Health Insurance Portability and Accountability Act (HIPAA) continues to be an area of great concern for health care providers and their business associates, and this session will provide insight into the enforcement process directly from an Office for Civil Rights (OCR) representative. The possibility of regulatory fines, patient class actions, and harmful publicity create significant enterprise risk, and monitoring HIPAA enforcement is crucial for attorneys with health care clients. This panel will provide an update on HIPAA enforcement and offer tips for staying out of OCR's crosshairs. Topics will include:

- OCR Enforcement Statistics: Trends identified by OCR and what to expect from OCR in enforcement and guidance initiatives in 2016, including discussion of HIPAA audits and breach investigations;
- Discussion of OCR case examples and de-identified HIPAA cases/ issues, including tips for training workforce members to learn from the mistakes of others;
- Proactive strategies for preventing breaches and preparing for a potential OCR investigation and/or audit, emphasizing both expected documentation and implementation strategies;
- Identification of a high impact case that may lead to enforcement, including OCR discussion of criteria it looks at when identifying such a case, and signs that may suggest a case is headed to formal enforcement/potential settlement; and
- OCR enforcement as a source of enterprise risk: a discussion of potential financial liability and the ripple effects of consumer class actions, state Attorney General involvement, and Federal Trade Commission enforcement.

### Speakers:

Kathleen D. Kenney
Polsinelli PC

Iliana L. Peters
Office for Civil Rights

Michaela D. Poizner
Baker Donelson Bearman Caldwell & Berkowitz PC

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