MedPAC Recommends 1.1% Increase in Physician Payments for 2009

by Kathleen Ream, Director of Government Affairs

On January 10, the Medicare Payment Advisory Commission (MedPAC) voted to recommend that physicians in 2009 receive a 1.1% increase in payments over 2008. The recommendation, which is to appear in MedPAC’s March report to Congress, is based on a staff report indicating that beneficiary access to physicians is still reasonably good. In addition, the recommendation is intended to address whether payments are adequate, as well as whether they should be updated.

Commission Chair, Glenn Hackbarth, said that the recommendation means that the commissioners are sending a message that they do not believe physician fees should be cut or frozen. Regardless of MedPAC’s recommendations to Congress, however, physicians’ fees are determined by the sustainable growth rate (SGR) formula that would have resulted in a 10.1% decrease for doctors in 2008, until Congress intervened at the end of 2007.

The 2009 MedPAC recommendation comes at a time when the issue of physician payments for 2008 is in flux. The Medicare, Medicaid and SCHIP Extension Act of 2007, signed by President Bush December 29, 2007, converted the 10.1% cut in reimbursements required by the SGR formula into a 0.5% increase. That increase expires on June 30, however. The $3.1 billion six-month increase is being paid for in part by a fund that CMS set aside for the Physician Quality Reporting Initiative (PQRI), a program under which physicians who report quality measures are eligible for extra payments. The Tax Relief and Health Care Act of 2006 allocated $1.35 billion to be used for either the 2008 PQRI bonus payments or for physician fees. While CMS had decided to use the money for the PQRI, Congress overrode that decision in the bill signed at the end of December, so that most of the money is being used to fund the 0.5% increase. In the 2007 legislation, Congress did extend the PQRI to 2009, but will fund it through the Supplementary Medical Insurance (Part B) Trust Fund, without the $1.35 billion cap on total funding that was in the 2006 law.

The 2007 law also established a $5 billion pool of funds for future doctor updates. MedPAC’s principal policy analyst, John Richardson, said that, in light of the fact that under the current SGR formula there will be cuts in physician payments through 2016, “The important takeaway at this point is to be aware of the fund’s existence.”

No Material Facts: EMTALA Suit Dismissed

Based on a plaintiff’s insufficient evidence, on January 29, 2008, the U.S. District Court for the Eastern District of Pennsylvania dismissed an EMTALA claim that a hospital was liable for failure to stabilize an unborn baby in imminent danger (Torretti v. Paoli Memorial Hospital, E.D. Pa., No. 06-3003, 1/29/08).

The Facts

Plaintiff Honey Torretti, 34 weeks into pregnancy with a second child, phoned her obstetrician on a Friday voicing a concern about pre-term labor and decreased fetal movement, but suspected that the condition was not an emergency. Her doctor advised her to keep a routine outpatient testing appointment, which previously had been scheduled for the following Monday, at the Paoli Memorial Hospital Testing Center (defendant). Following an examination of the routine tests that Monday, Torretti was advised to go directly to the hospital where her obstetrician practices and where further monitoring could continue in an inpatient setting.

No ambulance was called for Torretti as the doctor at the testing center did not perceive an acute emergency. Torretti was admitted to the second hospital in “pre-term labor and with ‘non reassuring [fetal heart tones].’” A baby boy was delivered having low Apgar scores and in need of resuscitation and ventilation. The baby suffered permanent mental and physical damage.

Plaintiff brought suit against Paoli Memorial Hospital claiming that defendant violated EMTALA requirements to conduct an appropriate medical screening, to stabilize treatment of an unknown emergency condition and to restrict transfer until a patient is stabilized. Following discovery, defendant sought summary judgment on the EMTALA count.

The Ruling

The standard for deciding summary judgment requires that the moving party “bears the burden of proving no genuine issue of material fact is in dispute and the court must review all of the evidence in the record and draw all reasonable inferences in favor of the nonmoving party.” Thus, the federal district court iterated that to establish an EMTALA stabilization violation, “Torretti must prove she had ‘an emergency medical condition, 2) the hospital actually knew of that condition, [and] 3) the patient was not stabilized before being transferred.’”

Recognizing that a reasonableness standard does not apply, the court stated that EMTALA duties will not arise when a hospital does not know of or diagnose any particular emergency medical condition. The court’s obligation in this case then was to determine whether there was sufficient evidence to sustain the claim under EMTALA, by examining defendant’s knowledge of plaintiff’s condition “in relation to cases in which EMTALA liability has been found for failure to stabilize and in relation to cases in which no liability has been found for failure to stabilize.” Numerous relevant cases were reviewed by the court and discussed in the opinion.

The district court found that plaintiff appeared at the hospital at the anticipated time of a previously scheduled appointment; Torretti did not present herself to the hospital as an emergency patient, nor did the nurse or doctor at defendant’s testing center exhibit “any indication [plaintiff’s] condition was an emergency.” The court also determined that plaintiff’s expert witness addressed only what the testing center doctor “should have known,” not what the physician “actually knew at the time.” Such testimony may sustain a medical malpractice suit but, wrote the court, “it is not enough to support a claim under EMTALA.” Summary judgment was granted for Paoli Memorial Hospital.

To read the court’s decision, go to http://op.bna.com/hl.nsf/r?Open=psts-7bdnvs. continued on page 20
Another EMTALA Disparate Treatment Claim Dismissed

On January 23, 2008, the U.S. District Court for the Eastern District of Missouri ruled against the claim that the medical screening received at an ED was in violation of EMTALA because it was disparate from the screening received by individuals presenting with similar symptoms (Mead v. Salem Memorial District Hospital, E.D. Mo., No. 4:07CV452, 1/23/08).

The Facts

In April 2005, Bobbie Mead (plaintiff) presented to the ED at Salem Memorial District Hospital (defendant) “with neurological signs and symptoms, including but not limited to left sided weakness.” Mead came under the care and treatment of Chukwuemeka M. Ekeke, MD (defendant). Ekeke discharged Mead after examining him and diagnosing a “mild TIA, left calf strain.”

Later, Mead was “transported to St. John’s Hospital via air ambulance with a diagnosis of acute stroke.” Plaintiff claimed that as a result of the stroke, he “suffered permanent and progressive neurological injury and damage, including but not limited to paralysis.” Three years later in March 2008, Mead filed a complaint against defendants seeking damages for alleged negligent medical treatment under Missouri law and alleging a violation of EMTALA.

For the EMTALA claim, Mead argued that Ekeke 1) failed to provide an appropriate medical screening examination within the capability of the ED; 2) failed to appropriately diagnose the emergency medical condition, thus jeopardizing plaintiff’s health; and 3) failed to stabilize or to provide stabilizing treatment. Defendants filed a motion to dismiss, contending that Mead’s complaints are “insufficient to invoke federal jurisdiction under EMTALA.”

The Ruling

The federal district court reviewing this case acknowledged that allegations in a complaint must be construed in plaintiff’s favor when examining a motion to dismiss. And too, the court noted that a “complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of the claim that would entitle plaintiff to relief.”

Proof of a lack of uniform treatment with other similarly situated patients is the cornerstone of an EMTALA claim. Yet, the court found that nowhere in Mead’s complaint does he “mention that there was any disparate treatment involved.” Rather, the court pointed out that plaintiff’s claim is that Ekeke and the hospital “failed to properly treat and/or diagnose Plaintiff’s condition, which is not a proper basis for stating a claim under EMTALA.” Also as required by EMTALA, Mead neglected to allege that the “hospital determined or had any actual knowledge that he had ‘an emergency medical condition,’ which the hospital failed to stabilize.”

Therefore, the U.S. District Court for the Eastern District of Missouri dismissed Mead’s case for “failure to state a claim upon which relief can be granted . . . [and] for lack of subject matter jurisdiction.”

To read this opinion, go to http://op.bna.com/hl.nsf/id/psts-7barcr/$File/mead.pdf.

EMTALA Screening of Inpatient Applies to Unborn Child

On January 24, 2008, the Wisconsin Court of Appeals, District IV, affirmed that EMTALA’s medical screening requirement does not apply to inpatients, including this case of a premature infant born after his mother was admitted to a hospital and taken to the hospital birthing center where the infant was birthed (Preston v. Meriter Hospital Inc., Wis. Ct. App., No. 2006AP3013, 1/24/08).

The Facts

Shannon Preston (plaintiff) arrived at Meriter Hospital (defendant) on November 9, 1999, where she was admitted and taken to Meriter’s birthing center. More than ten hours later, Preston gave birth to a baby boy, weighing one and one-half pounds and who could not survive on his own (i.e., absent resuscitation and the administration of oxygen and fluids). The baby was provided nursing care, but the hospital did not resuscitate or treat the child, who survived for two and one-half hours.

Preston sued Meriter for medical negligence, for failing to obtain informed consent, for neglecting a patient and for violating EMTALA, 42 U.S.C. § 1395dd. A circuit court dismissed the claims. Preston appealed the dismissal and, in 2004, the District IV Court of Appeals affirmed the lower court’s ruling. [See Preston v. Meriter Hosp., Inc. (Preston I), 2004 WI App 61, 271 Wis. 2d 721, 678 N.W.2d 347.]

Plaintiff then appealed to the Wisconsin Supreme Court, seeking a review of the appellate court ruling. [See Preston v. Meriter Hosp., Inc. (Preston II), 2005 WI 122, 284 Wis. 2d 264, 700 N.W.2d 158.] The Supreme Court reversed the dismissal “based on its determination that the phrase ‘comes to the emergency department’ applies to the hospital’s birthing center as well as to its emergency room.” However, the high court remanded the case for briefing on the issue of whether the EMTALA “screening requirement applies to inpatients or whether the newborn infant of a woman who is herself admitted to the hospital is also an inpatient by virtue of the mother’s admission.”

On remand, defendant moved for summary judgment on the inpatient issue, which the circuit court granted, noting that Preston’s child became an inpatient, at the same time as Preston, and remained so until his subsequent death. Plaintiff then appealed the inpatient ruling.

The Ruling

Plaintiff argued that the state’s supreme court holding that a “newborn has come to a birthing center for purposes of the screening requirement, the court implicitly held that the screening requirement continues to be in effect even after a patient’s admission.” The District IV appeals court, however, also saw that the higher court’s question of the premature baby’s inpatient status “could affect the validity of Preston’s screening requirement claim.”

Finding that EMTALA is silent as to whether the screening requirement applies to inpatients, the appellate judges looked to numerous federal courts of appeal that have decided upon this issue, as well as to the U.S.
The New York State Chapter (NY AAEM) took a proactive stance when they became aware that an emergency department within the state of New York was choosing the next contract holder, and among those under consideration, was a corporate contract group.

The New York Education Law forbids corporations from practicing medicine [§6527(1)]. Corporations cannot hire doctors to act on their behalf and take profit from the services rendered. Splitting fees is also restricted by NY case law [United Calendar Mfg. Corp. v. Huang, 463 NYS 2d 497 (NY App. Div. 1983)].

Given the situation, NY AAEM and AAEM sent a letter to the hospital expressing their concern about the possible violation of EP rights, as well as possible violation of New York law. The letter can be found at http://www.aaem.org/secure/repository/files/docs/1203101382-Lenox_Hill_Support_Letter_8_14_07.pdf. In the end, the hospital selected a new ED director and has made a commitment to have all EM board certified physicians.

Are you interested in joining NY AAEM or another state chapter? Please sign up today at https://ssl18.pair.com/aaemorg/membership/application.php. Are you interested in setting up a State Chapter? Please see http://www.aaem.org/statechapters/ for more information.

Department of Health and Human Services regulations, 42 C.F.R. § 489.24 (2003), clarifying that “EMTALA’s stabilization requirement does not apply once a patient is admitted to a hospital.” Determining that there is “no principled basis upon which to distinguish between the screening requirement and the stabilization requirement in the context of a person’s status as an inpatient,” the Wisconsin court then decided that a hospital’s obligation under the EMTALA screening requirement “ceases to apply once an individual has been admitted to a hospital for inpatient care.” Upon admission, wrote the court, the patient’s care “is then governed by state tort and medical malpractice law which all jurisdictions agree EMTALA was not intended to preempt.”

Turning to the issue of whether Preston’s baby was an inpatient at Meriter hospital, the court of appeals cited the lower court’s statement that the care plaintiff received was “inexorably linked to the fact that she was carrying her unborn child.” The court concluded that birth was the treatment for which plaintiff presented and was the treatment affecting the premature baby. The Wisconsin appellate court ruled that the EMTALA screening requirement does not apply “when a hospital provides inpatient care to a woman that involves treating her fetus simultaneously, the unborn child is a second inpatient, admitted at the same time as the mother.”

Go to http://www.wicourts.gov for more details of this opinion.