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Attorneys:

- **Collin P. Baron**
  cbaron@pullcom.com
  203.330.2219
- **Elliott B. Pollack**
  ebpollack@pullcom.com
  860.424.4340

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In This Winter 2012 Issue:

Lyme, Connecticut is Not Alone

The lack of vaccines to prevent noroviruses was noted in an original article in *The New England Journal of Medicine* on December 8, 2011. A leading cause of epidemic acute gastroenteritis, one of the noroviruses, termed the " Norwalk virus," was the subject of "a randomized, double-blind, placebo-controlled trial" to determine the efficacy of an experimental vaccine. In a study conducted by Dr. Robert L. Atmar and colleagues at the Baylor College of Medicine, the researchers concluded that "[v]accination significantly reduced the frequency of Norwalk virus gastroenteritis."

The shoreline Connecticut town of Lyme, which gave its name to the multi-system bacterial infection caused by the Borrelia Burgdoferi bacterium, now called Lyme disease, is not alone in the dubious distinction of having a disease condition named after it! The Norwalk virus acquired its nickname as a result of

the infection of school children in Norwalk, Connecticut in 1968.

Will New Payment Approach Work?

A prominent group of orthopedic surgeons has entered into an interesting joint venture with Saint Francis Hospital and Medical Center, the hospital at which they practice. According to Deirdre Shesgreen's article in ctmirror.org, an online publication, "[t]hey share financial data, analyze complication and readmission rates together, and they've even started billing collectively, at least for a handful of targeted patients."

The purpose of this experiment, conducted under a pilot program inaugurated by the Centers for Medicare & Medicaid Services (CMS) last year, is to incentivize physicians and hospitals to focus on coordinating care and to develop treatment plans for patients emphasizing effective care rather than episodic encounters.

Although as of the middle of last year, this pilot program had been focused on only about six patients, the hope is that by working together to understand the nature of the proposed care and the potential for complications, health care professionals will be able to reduce redundancy and excessive care.

At the same time, basing reimbursement on a predetermined lump sum puts providers in the position of underwriting the costs of "unpredictable outcomes." Will "a mutual sense of responsibility and accountability" between institutions and physicians, as one physician characterized it, improve care and save the system money? Further experience will offer more comprehensive answers to these questions while the Saint Francis orthopedists and the Hospital attempt to negotiate third party payment arrangements with a commercial carrier to include privately insured patients within the uninsured pilot plan. Assuming some success here, the joint venture may well seek participation in the CMS program too.

Elliott B. Pollack, Esq., who can be reached at (860) 424-4340 or ebpollack@pullcom.com, is knowledgeable about reimbursement issues.

Health Care in Financial Trouble

With all of the partisan political attacks on health care reform over the last many months and the general gloom and doom tenor of much media commentary, Philip Betbez, writing for *HealthLeaders Media* asks, why "so many private equity companies (are) jumping into health care?" One market research company theorizes

that, according to Mr. Betbez, as more non-Medicare/Medicaid patients obtain coverage through the statewide insurance exchanges created by the Reform Act, hospitals' financial performance will improve. Another source of revenue, the reporter suggests, may be obtained from the physician practices and other ancillary businesses hospitals have been buying lately, potentially generating significant profits.

While Mr. Betbez is not convinced, the decision of groups like Cerberus Capital Management and the Blackstone Group may prove instructive.

Liability after Specialist Referral?

Dr. Abimbola Osunkoya referred a patient to an ENT specialist after observing that her tonsils were large and red and diagnosing her as suffering from tonsillitis. After the referral, he never saw the patient again.

The ENT physician, Dr. Cooper, performed a tonsillectomy. In the medical malpractice action against both doctors which followed, the patient asserted that her primary care physician, Dr. Osunkoya, was negligent because he had insufficient evidence to support his diagnosis of tonsillitis and otherwise did not properly care for her.

There was no knowledge that the specialist was incompetent or that there was some improper arrangement between Dr. Osunkoya and the specialist, and the action against Dr. Osunkoya was dismissed because furthermore he "had no direct or indirect involvement in (his patient's) care after referring her . . . ." To the extent that Dr. Osunkoya was allegedly negligent in his care before he referred her to the ENT specialist, the action also was defective because there was no claim in the law suit that the patient suffered any harm before the specialist referral.

Proximate cause is still required to recover for negligence in civil tort actions; the court could find no credible allegation of proximate cause here.

Spicer v. Osunkoya, Delaware Supreme Court, Docket No. 102, 2011 (November 15, 2011).

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Health Care Reform and Tax Exemptions

In 2007, the Internal Revenue Service noted that approximately 50 percent of all nonprofit hospitals spent 3 percent or less of their gross revenues on charity care while at the same time paying their executives handsomely and vigorously chasing patients who could not pay their bills.

The Patient Protection and Affordable Care Act (PPACA) addresses some of these concerns. For example, hospitals can not charge indigent patients "more than the amounts generally billed to insured patients . . ." Among other objectives, this rule will make it more difficult for hospitals to claim high levels of charity care when they write off inflated bills to low income individuals.

"Extraordinary collection actions," a term to be defined, may not be pursued until the hospital knows whether a patient is eligible for financial assistance.

Hospitals must promulgate a financial assistance policy that includes a procedure for patients to apply for help. What will these requirements accomplish?

Critics suggest that PPACA does not do much to change existing practices and that not-for-profit hospitals need to do more. For example, they argue that hospitals should look out for their communities by adopting measures to improve the health of an area's population rather than addressing charitable goals through individual care.

Given litigation which seems to pop up frequently concerning the interpretation of the charity care rules currently in place through the Internal Revenue Service, the new requirement of PPACA that tax-exempt hospitals prepare an assessment of community health needs at least every three years is a promising development.

For further information, please contact Tiffany K. Spinella, Esq. at (860) 424-4360 or tspinella@pullcom.com.

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New Data Bank Protocol

In the past, physicians were routinely advised by the National Practitioner Data Bank when an entity entitled to view information in the Data Bank, such as a hospital or other organization which conducts peer review, a regulatory body or federal and state governmental health care programs, was checking their records. Effective December 23, 2011, this practice has been ended.

Another Turf Battle?

Back in 2010, the Connecticut State Dental Commission began a declaratory ruling proceeding. The intention was to determine whether or not "teeth whitening practices and/or procedures constitute the practice of dentistry as set forth in ... the Connecticut General Statutes."

After hearings, the Commission concluded that teeth whitening procedures are dentistry if they "involve diagnosis, evaluation, prevention or treatment of an injury or deformity, disease or condition of the oral cavity (such as discoloration)." The Commission found that those who perform such procedures are practicing dentistry illegally. Teeth whitening, the Commission held, "becomes the practice of dentistry when (light is used) in an attempt to enhance the product's effectiveness...."

Citing risks associated with teeth whitening, the Commission ruled that dental x-rays were required before commencing teeth whitening procedures for the purpose of detecting "caries, defective restorations or pulpal pathology" or other conditions the Commission held should be treated prior to bleaching. It did not choose to sanction the sale of whitening products, such as teeth gels.

What is interesting here is the Commission's reluctance to take on the sale of teeth whitening products for use at home prior to a dental examination. Is it acceptable for patients to be furnished with the means to harm themselves potentially with this product while invalidating the commercial, non-dentist's application for same product?

The Health Law Department's understanding is that this declaratory ruling is being challenged. We will report on further developments in future issues of *Health Care Insights*.

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For further information, please contact Karen A. Daley, Esq. at (203) 330-2143 or kdaley@pullcom.com.