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In This Issue:

INDUSTRY HOT TOPICS
Anesthesiologist Assistant May Perform Epidural and Spinal Anesthetic Procedures Under Anesthesiologist's Direct Supervision 1

MEDICARE / MEDICAID
CMS Requires All Hospitals to Meet Requirements for Handling of Emergency Patients 1

IRS GUIDANCE
IRS Amends and Clarifies Form 990 Instructions 2

IRS Allows Tax-Exempt Hospitals to Subsidize EHR Technology 2

MEDICAL RECORDS
Ohio District Court Orders Hospital to Disclose Confidential Medical Records 3

LONG-TERM CARE
Ohio Supreme Court Decides Nursing Homes May Discharge Residents for Nonpayment of Fees 3

LABOR AND EMPLOYMENT
Ninth Circuit Holds Nurse's Discrimination and Retaliation Claims Not Preempted by Federal Law . . .4

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INDUSTRY HOT TOPICS

Anesthesiologist Assistant May Perform Epidural and Spinal Anesthetic Procedures Under Anesthesiologist's Direct Supervision

The Ohio Supreme Court held that an Ohio State Medical Board's (the "Board") rule prohibiting anesthesiologist assistants from performing epidural and spinal anesthetic procedures conflicted with state law and, therefore, was invalid. *Hoffman v. State Med. Bd. of Ohio*, 113 Ohio St. 3d 376, 865 N.E.2d 1259 (Ohio 2007).

Hoffman, a certified anesthesiologist, routinely performed spinal and anesthetic procedures since 1982. In 2003, the Board adopted Ohio Admin. Code 4731-24-04(A) (2003) (the "Rule"), which prohibits anesthesiologist assistants from performing those procedures. Hoffman filed an action for declaratory and injunctive relief, arguing that the Rule conflicts with Chapter 4760 of the Ohio Revised Code, which permits an anesthesiologist assistant to "assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures." The trial court granted summary judgment in favor of Hoffman. The court of appeals reversed, finding that the legislature intended the term "assist" to mean to aid or help. As a result, the court of appeals concluded that the provisions of the Rule did not conflict with the Revised Code.

The Ohio Supreme Court interpreted the term "assist" in the Rule to permit an anesthesiologist assistant to "carry out procedures as requested by the supervising anesthesiologist, provided that the requested procedure is within the anesthesiologist assistant's training and scope of practice, is authorized by the practice protocol adopted by the supervising anesthesiologist, and is not prohibited by Chapter 4731 or 4760 of the Revised Code . . . ." In addition, the Court noted that "assist" has a technical meaning in anesthesiology: to perform the help that is needed by a physician, including the actual performance of procedures. Applying rules of statutory construction, the Court noted that the term should be construed according to its technical definition. Because the term "assist" includes the performance of procedures, the Rule conflicts with the Revised Code.

It is important to note that while an anesthesiologist assistant is allowed to perform or administer procedures, the assistant still must be directly supervised by an anesthesiologist who is physically present in the room.

MEDICARE / MEDICAID

CMS Requires All Hospitals to Meet Requirements for Handling of Emergency Patients

On April 26, 2007, the Centers for Medicare and Medicaid Services ("CMS") issued a Memorandum to State Survey Agency Directors regarding the provision of emergency services by hospitals participating in the Medicare program.

The Memorandum states that all hospitals, even hospitals without emergency departments, as a condition of participation in the Medicare program, must have policies and procedures in place for addressing individuals' emergency care needs 24 hours per day and 7 days per week, including the following:

- Conducting Appraisals of Persons with Emergencies - All hospitals must make a registered nurse immediately available to provide bedside care to any patient at all times. The registered nurse must be qualified, through a combination of education, licensure and training, to conduct an assessment of a person's

MEDICARE / MEDICAID *Continued on page 2*

Medicare / Medicaid

Continued from page 1

need for emergency care. A physician, either on-site or on call, must directly provide appraisals of emergencies or medical direction of on-site staff conducting such appraisals.

- Initial Treatment of Persons with Emergency Conditions - A qualified registered nurse must be available at all times in the hospital. The nurse may be qualified, through a combination of education, licensure and training, to provide initial treatment to a person experiencing a medical emergency. The on-site or on-call physician should provide initial treatment directly or provide medical oversight direction to other staff. The hospital should evaluate its typical patient population in order to anticipate potential emergency care scenarios.
- Referrals of Patients to Appropriate Facilities - Policies and procedures should be designed to enable hospital staff members who respond to emergencies to recognize when a person requires a referral or transfer, and assure appropriate handling of the transfer, including arrangement for appropriate patient transport. Hospitals must transfer patients only to appropriate facilities capable of handling the patient's condition. Necessary medical information must be sent along with the patient being transferred to enable the receiving hospital to treat the medical emergency more efficiently.
- Use of 911 - The hospital may arrange transportation for a referred patient by several methods, including the hospital's own ambulance service, the receiving hospital's ambulance service, a contracted ambulance service, or, in extraordinary circumstances, alerting EMS via a 911 call. The Memorandum stresses that use of 911 to obtain transport is not prohibited by Medicare, but it does not relieve the transferring hospital of its obligation to arrange for the patient's transfer to an appropriate facility and to provide the necessary medical information along with the patient. A hospital that routinely relies on 911 calls to transfer emergency patients instead of its own emergency response capabilities violates the conditions of Medicare participation.

While the Memorandum instructs state surveyors to evaluate all hospitals' compliance with these Medicare emergency treatment requirements, it appears that the CMS is particularly focused on enforcing the emergency handling requirements at specialty hospitals. The Memorandum is at least partly in response to a recent Texas incident where a patient who had experienced an emergency while being treated in a specialty hospital died in transit to a local acute care hospital.

IRS GUIDANCE

IRS Amends and Clarifies Form 990 Instructions

The IRS recently amended and clarified its instructions to the 2006 version of Form 990. IRS Form 990 is an information return for hospitals and other tax-exempt organizations that provide financial information about the filing organization and helps government agencies enforce the laws governing tax-exempt organizations.

The most significant change narrows the classification of Line 75c "related organizations." A tax-exempt organization must report compensation paid to its executives from "related organizations." The original Form 990 instructions classified organizations as "related organizations" resulting from eight relationships. However, the IRS amended the instructions to disregard Relationship 6 (the organizations are partners or members of an LLC or other joint venture) and Relationship 8 (at least one person exercises substantial influence over both organizations). Therefore, these relationships no longer cause organizations to be related, and tax-exempt organizations no longer need to include compensation information from these previously "related organizations" on Line 75c.

Furthermore, the IRS clarified the controversial business relationship provisions of the Form 990. The IRS limited the scope of Line 75b, which inquires about family or business relationships between officers and directors. Line 75b only pertains to relationships between members of the filing organization, not members of related organizations. Additionally, corporate attribution rules do not apply, so organizations only report direct relationships. Further, addressing Line 75b's requirement to "attach a statement that identifies the individuals and explains the relationship," the IRS does not require the filing organization to provide the requested information if, after making a reasonable effort, the organization cannot obtain the information.

The IRS also clarified its policy regarding compensation to former officers and directors. Because no look-back period exists, tax-exempt organizations must make a reasonable effort to report compensation to all former officers and directors, regardless of when the person last exercised substantial influence over the organization. A hospital with a deferred compensation plan paying retired executives for twenty years or longer must make a reasonable effort to report the payments in Part V-B. This is required even though a retired executive may not have been employed or exercised substantial influence for decades.

Overall, the clarifications and modifications to the Form 990 instructions greatly limit relationships resulting in "related organization" status, and stress the importance of using "reasonable efforts" to obtain required information.

The full text of the IRS guidance is available at http://www.irs.gov/pub/irs-tege/2006_form_990_qas_final.pdf.

IRS Allows Tax-Exempt Hospitals to Subsidize EHR Technology

Tax-exempt hospitals may enter into certain arrangements with their medical staff physicians in order to facilitate physician use of electronic health record ("EHR") technologies without violating federal tax law, according to an IRS directive (the "Directive") issued May 11, 2007. The Directive effectively establishes a safe harbor for tax-exempt hospitals that wish to enter into such arrangements.

Hospitals seek to subsidize EHR technology because they believe that it will improve the quality of medical care by

IRS GUIDANCE *Continued on page 3*

IRS Guidance

Continued from page 2

allowing hospitals and physicians to share information. Prior to the Directive, the hospital community was concerned that providing such subsidies to physicians to encourage EHR technology use would be treated as a "private benefit" or "private inurement" that would violate Section 501(c)(3) of the Internal Revenue Code (the "Code"). However, the Directive provides guidance to hospitals on the procedures that they can follow in order to retain their tax-exempt status when providing these EHR subsidies to physicians.

The Directive follows the final regulations issued by the U.S. Department of Health and Human Services on the same topic (the "HHS EHR Regulations"). The HHS EHR Regulations, issued on August 8, 2006, allow hospitals to provide, within specific parameters, EHR software and technical support services ("Health IT Items and Services") to medical staff physicians without violating the federal anti-kickback law or physician self-referral law.

Pursuant to the Directive, the IRS will not treat the benefits a hospital provides to its medical staff physicians as an impermissible private benefit or private inurement in violation of Section 501(c)(3) of the Code if: (1) the benefits fall within the range of Health IT Items and Services that are permissible under the HHS EHR Regulations and (2) the hospital operates in the manner described below.

A hospital that is otherwise described in Section 501(c)(3) of the Code enters into Health IT Subsidy agreements with its medical staff physicians for the provision of Health IT Items and Services at a discount (the "Health IT Subsidy Arrangements"). The Health IT Subsidy Arrangements require both the hospital and the participating physicians to comply with HHS EHR Regulations. The Health IT Subsidy Arrangements provide that, to the extent permitted by law, the hospital may access all of the electronic medical records created by a physician using the Health IT Items and Services subsidized by the hospital. The hospital ensures that the Health IT Items and Services are available to all of its medical staff physicians. The hospital provides the same level of subsidy to all of its medical staff physicians or varies the level of subsidy by applying criteria related to meeting the healthcare needs of the community.

The legal community has generally embraced the Directive and applauded the IRS for tracking the HHS EHR Regulations.

MEDICAL RECORDS

Ohio District Court Orders Hospital to Disclose Confidential Medical Records

The United States District Court for the Northern District of Ohio recently held that an injured plaintiff may discover non-party patient hospital records if those records are necessary to establish her claim. *Soehnlen v. Aultman Hosp.*, No. 5:06 CV 1594, 2007 WL 1342508 (N.D. Ohio May 4, 2007).

In *Soehnlen*, Kathryn Soehnlen brought suit against Aultman Hospital, the American Red Cross, and several other defendants for injuries allegedly sustained while receiving a blood transfusion. Soehnlen claimed that the defendants were negligent in their failure to sanitize medical equipment. In establishing her case, Soehnlen sought to compel Aultman Hospital to disclose certain hospital records. Aultman Hospital attempted to prevent discovery of such documents, claiming physician-patient privilege.

Soehnlen's ability to discover the documents depended on whether the court applied federal or state common law principles on physician-patient privilege. The Federal Rules of Evidence compel a federal court to apply federal common law principles on privilege unless state law supplies the rule of decision. Therefore, this case turned on whether state law supplied the rule of decision.

The court determined that state law supplied the rule of decision. In reaching this decision, the court recognized that the case was in federal court solely because the American Red Cross was a named defendant and not because the case presented a federal question. Instead, the court focused on the nature of Mrs. Soehnlen's claim against Aultman Hospital and recognized that it was a state law-based tort claim. As such, Ohio law supplied the rule of decision and the ultimate rule for deciding the applicability of the physician-patient privilege.

In Ohio, confidential medical information is generally privileged against disclosure. Ohio courts, however, have recognized that a hospital may be forced to disclose confidential medical information when a countervailing interest outweighs the patient's interest in confidentiality. Given the nature of Ms. Soehnlen's injuries, non-party patient records were necessary to establish her claim. This necessity outweighed other patients' interest in confidentiality. Under those circumstances, the court ordered Aultman Hospital to disclose patient information.

LONG-TERM CARE

Ohio Supreme Court Decides Nursing Homes May Discharge Residents for Nonpayment of Fees

A nursing home may discharge a resident for nonpayment of charges incurred prior to Medicaid coverage, according to *Dayspring of Miami Valley v. Shepherd*, No. 06-CA-113, 2007 WL 1536917 (Ohio App. 2 Dist., May 25, 2007). In so holding, the Ohio Court of Appeals, Second District, reasoned that a Hearing Officer and trial court had utilized factors not listed in O.R.C. § 3721.13(A)(30) and had added an impermissible additional layer of proof not present in the statute.

The case began with a nursing home resident's denial of Medicaid coverage in January 2004. The nursing home and resident then entered into an agreement providing that the resident would be responsible for all charges incurred while she was a resident of the facility. When the resident's second application for Medicaid was later approved she began receiving coverage retroactive to August 2004. This coverage did not apply to the charges accumulated by the resident from January 2004 to August 2004, prior to the effective date of her Medicaid coverage.

In October 2004, the nursing home notified the resident that she was being discharged due to nonpayment of her bill

LONG-TERM CARE *Continued on page 4*

Long-Term Care *Continued from page 3*

pursuant to O.R.C. § 3721.13(A)(30), which provides that a nursing home resident may not be discharged unless the discharge is necessary due to one of a number of enumerated factors, such as nonpayment. The resident then requested a hearing in front of a Department of Health Hearing Officer to challenge the notice of discharge pursuant to O.R.C. § 3721.161(A). The Hearing Officer denied the discharge based on equitable factors not within the express language of O.R.C. § 3721.13(A)(30).

While finding that the nursing home had sufficiently demonstrated nonpayment, the Hearing Officer determined that, because the nursing home was complicit in helping to create the initial balance, it did not have clean hands. Thus, equity prevented the nursing home from discharging the resident. On administrative appeal, the trial court upheld the Hearing Officer's denial by finding that a nursing home not only has to show the existence of one of the statute's enumerated factors, but also must show that discharge was necessary in order to comply with O.R.C. § 3721.13(A)(30).

In reversing the trial court's ruling, the court of appeals found that the necessity of discharge was demonstrated solely by the existence of the factors provided in the statute, e.g., nonpayment. Further, the court stated that the underlying statute provided no equitable defenses or factors to be considered in determining whether that discharge is appropriate. Thus, the nursing home had complied with the statute by demonstrating that the resident had failed to make payments; the trial court and Hearing Officer's utilization of factors not listed in the statute was reversible error.

LABOR AND EMPLOYMENT

Ninth Circuit Holds Nurse's Discrimination and Retaliation Claims Not Preempted by Federal Law

The Ninth Circuit Court of Appeals recently held that a district court erred in finding that a nurse's claims of discrimination and retaliation were preempted by federal labor law. *Detabali v. St. Luke's Hosp.*, 482 F.3d 1199 (9th Cir. 2007).

Lorraine Detabali, an intensive care unit nurse and union representative at St. Luke's Hospital, was fired for insubordination, patient abandonment, and harassment of another staff member when she refused an order to cover the emergency room. Detabali initially sued St. Luke's in state court, bringing claims for breach of contract, breach of the covenant of fair dealing and good faith, and claims under California's Fair Employment and Housing Act ("FEHA") for discrimination on the basis of race and national origin, retaliation, and harassment. She responded to St. Luke's allegation of insubordination by contending that a provision in the collective bargaining agreement allowed ICU nurses to decline to work in the emergency room.

St. Luke's removed the case to federal court, alleging that Detabali's contractual claims were preempted by the federal Labor Management Relations Act ("LMRA"). Detabali responded by filing an amended complaint, which only included the state FEHA claims. The district court dismissed the amended complaint, saying the claims were still preempted by the federal LMRA, and that Detabali had failed to exhaust the LMRA-required grievance procedures. The court instructed Detabali to replead her state FEHA claims with facts demonstrating she was fired based on her membership in a protected class, and in a way that the claims would not be preempted by the federal LMRA. Detabali's second amended complaint did not differ substantially from her first amended complaint; the district court dismissed the complaint and fined Detabali's lawyer.

The Ninth Circuit reversed the district court, finding that the lower court had erred and misinterpreted the application of the federal LMRA. The Ninth Circuit found that the LMRA would preempt claims such as Detabali's state FEHA claims only if resolution of the claim depended upon the meaning of the collective bargaining agreement. There would be no such preemption if the claim only "tangentially" relied on a provision of the collective bargaining agreement.

The Ninth Circuit found that, while the adjudication of Detabali's discrimination claim would require reference to the collective bargaining agreement, since the terms of the collective bargaining agreement themselves were not at issue, the federal LMRA did not preempt her state discrimination claims. Because there was no preemption, the district court lacked jurisdiction to dismiss Detabali's case; thus, the Ninth Circuit remanded to the district court with instructions to remand the case to California state court. The Ninth Circuit also reversed the sanctions imposed on Detabali's attorney due to lack of jurisdiction.

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