

---

## CLIENT NEWSLETTER

---

### In This Issue:

Massachusetts Court Declines to Adopt Corporate Negligence Theory Against Hospital . . . . .	1
CMS Revises Emergency Medical Treatment and Active Labor Act . . . . .	2
OIG Issues Work Plan for FY 2007 . . . . .	3
NLRB Rules Charge Nurses are Supervisors Under NLRA . . . . .	4
Hospital's Property Tax Exemption Revoked. . . . .	5
OIG Permits Charitable Organization to Provide Assistance to Needy Medicare Beneficiaries . . . . .	6
President Bush Issues Executive Order Promoting High Quality Health Care . . . . .	8

---

**The Rogers Law Firm**  
100 Cambridge Street  
20<sup>th</sup> Floor, Suite 2000  
Boston, MA 02114  
(617) 723-1100

[www.therogerslawfirm.com](http://www.therogerslawfirm.com)

---

**Wilson D. Rogers, Jr.**  
**Peter Pommersheim**  
**Michael J. Fazio, Jr.**  
**Wilson D. Rogers, III**  
**Francis J. O'Connor**  
**Mark C. Rogers**  
**Megan M. Grew**  
**Robert E. Driscoll, Jr.**

### **Massachusetts Court Declines to Adopt Corporate Negligence Theory Against Hospital**

A Massachusetts Superior Court judge recently declined to adopt the theory of corporate negligence liability against a hospital, or its parent company, for the alleged medical malpractice of a physician on the hospital's medical staff. Although the ruling in *Ward v. Kylander, M.D., et al.*, 2006 WL 2141247 (Mass. Super. June 8, 2006), is only a Superior Court decision, it is significant in that states other than Massachusetts have adopted the theory of corporate negligence liability.

In September of 2000, the Plaintiff, Louis Ward, met with Dr. Clarence Kylander to discuss the possibility of undergoing a surgical procedure known as a stapedectomy on his left ear. During their meeting, Mr. Ward signed an informed consent form, which was witnessed by a nurse. After the surgery, Mr. Ward experienced several complications, including numbness and paralysis in his facial muscles, and loss of vision and hearing. Mr. Ward brought suit against Dr. Kylander, St. Vincent's Hospital ("Hospital") (where the surgery took place) and Tenet Healthsystem ("Tenet") (the parent company of the Hospital), alleging that he had not been properly informed of the risks and dangers associated with the stapedectomy and that he would not have elected to undergo the procedure had he been aware of the risks.

At the time of the surgery, Dr. Kylander was a private practitioner employed by Fallon Clinic. He was also a member of the medical staff at the Hospital, but he did not receive a paycheck or employee benefits from either the Hospital or Tenet. Furthermore, he did not have a contract with Tenet and he stated that he was not supervised by either Tenet or the Hospital. Dr. Kylander testified at his deposition that he considered himself to be an independent practitioner.

At the close of discovery, the Hospital and Tenet filed a Motion for Summary Judgment, arguing that based upon the evidence, they should not be held liable for the alleged malpractice of Dr. Kylander. In his decision granting Summary Judgment for the Hospital and Tenet, Judge John T. Lu first addressed Mr. Ward's claims of vicarious liability. It is

**The Rogers Law Firm has updated its website to include past editions of its Client Newsletter and Client Advisories. The website is located at [www.therogerslawfirm.com](http://www.therogerslawfirm.com).**

established law in Massachusetts that an employer or master should be held vicariously liable for the torts of his employee or servant committed within the scope of employment. In *Dias v. Brigham Medical*, 438 Mass. 317 (2002), the Massachusetts Supreme Judicial Court held that although a physician who generally acts as an independent practitioner is not subject to the direction or control of anyone else, a physician may still be deemed as a servant of a hospital in certain circumstances. These circumstances include a number of factors, such as whether the hospital pays the physician's salary, whether the parties believe that they have formed an employer-employee relationship, and whether the hospital has the right to direct and control the physician's treatment of patients. Obviously this is a fact-dependent determination. Judge Lu reviewed the record and concluded that Mr. Ward had failed to introduce sufficient evidence that would support a finding that Dr. Kylander was an employee of either Tenet or the Hospital. Instead, Judge Lu held that the only evidence presented was that Dr. Kylander was an independent contractor who was employed by an unrelated entity (Fallon Clinic) at the time of the alleged malpractice.

Judge Lu next addressed Mr. Ward's claims against Tenet and the Hospital under a theory of corporate negligence. This theory, which has been adopted in some jurisdictions, argues that Tenet and the Hospital should be liable because they assumed the role of arranging and coordinating the total health care of their patients. This theory of liability can be pursued even in the absence of an employer-employee relationship between the physician and the hospital. Judge Lu, however, held that Massachusetts has never before recognized such a theory, and therefore, he would not allow for such a theory to proceed in the case. Furthermore, Judge Lu held that Mr. Ward failed to provide any evidence suggesting a material issue of fact as to how Tenet or the Hospital failed in their duty to oversee persons practicing medicine within the Hospital, or their duty to adopt and enforce adequate rules and policies.

The Court's decision is significant in that it appears to be the first time a Massachusetts court has addressed the theory of corporate negligence liability in a medical malpractice case. The case will still proceed forward as against Dr. Kylander. However, it is possible that the Plaintiff will decide to appeal the Superior Court's decision granting Summary Judgment to the Hospital and Tenet.

The Rogers Law Firm will continue to monitor this case and keep you apprised of any developments.

## **CMS Revises Emergency Medical Treatment and Active Labor Act**

On August 1, 2006, the Centers for Medicare and Medicaid Services ("CMS") issued the Final Rule for the Inpatient Prospective Payment System ("IPPS"). The 2007 IPPS Final Rule contains a significant revision to the Emergency Medical Treatment and Active Labor Act ("EMTALA") regulations in regard to the definition of the term "labor".

Under EMTALA, when an individual comes to an emergency department, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether an emergency medical condition exists. 42 C.F.R. § 489.24(a)(1)(i). If an emergency medical condition exists, the hospital is required to provide any necessary stabilizing treatment or an appropriate transfer to another facility. 42 C.F.R. § 489.24(a)(1)(ii). The 2007 IPPS Final Rule amends the definition of labor under EMTALA to provide that "a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and state law, certified that, after a reasonable time of observation, the woman is in false labor." 42 C.F.R., § 489.24(b). The new definition expands the categories of individuals

who are permitted to certify that a woman is in false labor. Previously, the regulations provided that only physicians were permitted to certify “false labor”.

The amendment to the EMTALA regulations was proposed by the Technical Advisory Group created by CMS to review issues related to EMTALA and its implementation. CMS agreed with the recommendation as it was consistent with CMS’ current policy regarding health care personnel entitled to conduct medical screening examinations.

Hospitals should review their current policies to ensure compliance with the EMTALA regulations. The Rogers Law Firm is available to review these policies to ensure consistency in this regard.

## **OIG Issues Work Plan for FY 2007**

On September 25, 2006, the Office of Inspector General (“OIG”) of the United States Department of Health and Human Services (“HHS”) issued its Fiscal Year 2007 Work Plan. The OIG issues the Work Plan each year to detail its areas of focus over the next year. The Work Plan sets forth what the OIG believes to be vulnerabilities in programs and activities administered by HHS.

There are several areas which the Work Plan addresses, including specialty hospitals, inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, hospice, and Medicare Part D. Some of the more notable areas of concern listed in the Work Plan, include:

- **Unbundling of Hospital Outpatient Services**

The OIG states that it will determine the extent to which hospitals and other providers have been submitting claims for services that should be bundled into outpatient services. Bundling of services could lead to inappropriate Medicare payments.

- **“Inpatient Only Services” Performed in an Outpatient Setting**

The Work Plan states that the OIG will determine if Medicare payments are appropriately denied for “inpatient only” and related services performed in an outpatient setting and assess the extent to which Medicare beneficiaries are held liable for denied inpatient claims for these services.

- **Medical Appropriateness and Coding of Diagnosis Related Group Services**

The OIG states that it will analyze inpatient hospital claims to identify providers who exhibit high or unusual patterns for selected DRGs. The Work Plan states that the OIG has found the DRG system vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding.

- **Inappropriate Payments for Diagnostic X-Rays in Hospital Emergency Departments**

The Work Plan states that the OIG will determine the extent of inappropriate payments for diagnostic x-rays performed in hospital emergency departments. According to the Work Plan, in 2004, more than 2.5 million diagnostic x-rays were performed in Medicare-certified hospitals with emergency departments. The interpretations of these diagnostic x-rays by emergency room physicians should not be billed separately.

The Work Plan can be found at

<http://oig.hhs.gov/publications/docs/WorkPlan\2007\Work%20Plan%202007.pdf>.

## **NLRB Rules Charge Nurses are Supervisors Under NLRA**

The National Labor Relations Board (“NLRB”) issued a decision in the matter of *Oakwood Health Care*, 348 NLRB No. 37, on October 3, 2006, holding that permanent charge nurses in hospitals are to be considered supervisors under the National Labor Relations Act (“NLRA”). As a result of this decision, charge nurses will not be eligible to become members of a union.

The NLRB’s ruling in *Oakwood Health Care* arises from the United States Supreme Court’s decision in *NLRB v. Kentucky River Community Care*, 532 U.S. 706 (2001). In *Kentucky River*, the Supreme Court criticized the NLRB’s interpretation of the term “independent judgment” under the NLRA. The NLRA provides that individuals are to be considered supervisors if (1) they hold the authority to engage in any one of the twelve supervisory functions listed in § 2(11) of the Act; (2) their “exercise of such authority is not of a mere routine or clerical nature, but requires the use of independent judgment”; and (3) their authority is held “in the interest of the employer.” Under § 2(11) of the NLRA, a supervisor is defined as “any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.” In *Kentucky River*, the Supreme Court criticized the NLRB’s extant interpretation of the term “independent judgment” under § 2(11). As a result, the NLRB sought to use its decision in *Oakwood Health Care* to re-examine and clarify its interpretation of the term “independent judgment.”

In *Oakwood Health Care*, the NLRB ruled that twelve permanent charge nurses employed by Oakwood Heritage Hospital, an acute care hospital, exercised supervisory authority in assigning employees within the meaning of § 2(11) of the NLRA. The NLRB ruled that charge nurses with the authority to assign other nursing personnel to specific patients for treatment were supervisors because the authority to assign other nurses required the exercise of independent judgment. The NLRB concluded that in order to be independent, the judgment exercised by a supervisor must not be effectively controlled by another authority. Furthermore, the degree of discretion exercised by the supervisor must rise above the “routine or clerical” in order to constitute “independent judgment” under the NLRA. The NLRB found that a “charge nurse’s analysis of an available nurse’s skill set and level of proficiency at performing certain tasks, and her application of that analysis in matching that nurse to the condition in need or a particular patient, involves a degree of discretion markedly different than the assignment decisions exercised by most leadmen.” The NLRB did rule, however, that the hospital’s rotating charge nurses could not be considered supervisors under the NLRA, because they did not exercise such supervisory authority in the regular course of their duties.

In two companion cases which were released by the NLRB in conjunction with *Oakwood Health Care*, the NLRB provided further guidance on supervisors under the NLRA. In *Croft Metals, Inc.*, 348 NLRB No. 38, the NLRB held that although “leadpersons” at the employer’s manufacturing plant had the authority to manage their assigned teams, they were not supervisors because their exercise of judgment was either fundamentally controlled by pre-established guidelines or was simply routine. Furthermore, in the NLRB’s decision in the matter of *Golden Crest Healthcare Center*, 348 NLRB No. 39, the NLRB found that charge nurses at a nursing home did not exercise supervisory authority under the NLRA. The NLRB found that the charge nurses at the nursing home lacked the authority to assign tasks to other nurses, require other employees to stay past the end of their shifts, to come in from off-duty status, or to shift section assignments.

The NLRB’s decisions provide much-needed guidance with respect to classification of charge nurses as supervisors under the NLRA. It is now clear that in most hospitals, permanent charge nurses will be considered supervisors under the NLRA.

## **Hospital’s Property Tax Exemption Revoked**

The Illinois Department of Revenue recently upheld the revocation of the property tax exemption of Provena Covenant Medical Center (“Covenant”). The revocation was based on the Department of Revenue’s conclusion that Covenant was no longer primarily operating for a charitable purpose. While the revocation of Covenant’s property tax exemption is based on Illinois law, the decision could have a far-reaching impact on tax-exempt hospitals throughout the United States.

Covenant is a 270 bed acute care hospital in Urbana, Illinois. The hospital is part of Provena Health, which is a Catholic-sponsored integrated health care delivery system. In 2002, Covenant sought a property tax exemption by filing an application with the Champaign County Board of Review (“Board”). The Board recommended that the application be denied. The Department of Revenue subsequently agreed with the Board’s recommendation and Covenant appealed the ruling to an administrative law judge. The administrative law judge recommended that Covenant be granted tax-exempt status. However, on September 29, 2006, the Department of Revenue rejected the recommendation of the administrative law judge and reaffirmed its denial of property tax exemption for Covenant.

The Department of Revenue ruled that the issue with respect to Covenant was “whether the property used by Covenant is owned by a charitable organization and, if so, whether the property is used by that organization exclusively for charitable purposes.” Under Illinois law, there is a tax exemption for property that is actually and exclusively used by institutions of public charity for a charitable or beneficent purposes, and not otherwise used with a view to profit. The Department of Revenue held that several factors contributed to its denial of tax exemption for Covenant. In particular, the Department of Revenue noted that Covenant spent only \$832,000 or 0.7% of its \$113.5 million in revenues on charitable care expenses in 2002. In comparison, Covenant’s property tax exemption that year was valued at over \$1.1 million. The Department of Revenue also criticized Covenant’s emergency care. The Department of Revenue noted that a for-profit physician corporation staffed Covenant’s emergency facilities. The corporation billed and collected for its own services. Covenant maintained that the physician corporation was bound to follow Covenant’s charity care policy, but the Department of Revenue found no evidence indicating that the corporation complied with that policy. The Department of Revenue further criticized what appeared to be Covenant’s failure to verify that other third

parties in its facility (pharmacy, laboratory, videology, neonatology, rehabilitation and cardiovascular surgery) complied with Covenant's charity care policy.

The Department of Revenue also criticized Covenant's charity care policy. In particular, the Department of Revenue felt that Covenant's charity care policy did not provide for a meaningful evaluation of a patient's ability to pay. Furthermore, the Department criticized the statement in Covenant's charity care policy that Covenant would provide charity care "to the extent that it is financially able." In consideration of Covenant's charity care practices, the Department of Revenue characterized this statement as raising further doubt in regard to whether Covenant provided charity care to an indefinite number of people as required under Illinois law.

In response to the ruling, Covenant has vigorously defended its charity care practices and has vowed to appeal the ruling by the Illinois Department of Revenue. Since losing its tax-exempt status in January of 2003, Covenant has paid nearly \$5 million in property taxes. (It should be noted that the Department of Revenue's ruling does not effect Covenant's state or federal income tax exemptions.) Covenant argues that there are no clear rules as to what exactly qualifies as a charitable institution. In particular, it believes that bad debt, or unpaid medical bills, should be counted as charity care. Furthermore, Covenant points out that the Department of Revenue's ruling does not take into account the hospital's community services, immunizations, health fairs and prevention programs.

The ruling by the Illinois Department of Revenue with respect to Covenant's property tax exemption may have far-reaching effects on other non-profit hospitals throughout the United States. Non-profit hospitals are currently under intense scrutiny by federal, state and local governments with respect to their tax exemption status. In 2004, the Massachusetts Appeals Court upheld the ruling of the Appellate Tax Board's denial of a hospital foundation's application for a property tax abatement. Sturdy Memorial Foundation, Inc., a charitable entity organized to oversee the operations of, and otherwise support, Sturdy Memorial Hospital, was found by the local Board of Assessors to not be operating as a charity.

The Rogers Law Firm will monitor Covenant's appeal of the Illinois Department of Revenue's ruling and will provide updates accordingly.

## **OIG Permits Charitable Organization to Provide Financial Assistance to Needy Medicare Beneficiaries**

On September 21, 2006, the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") issued an advisory opinion approving a tax-exempt charitable organization's practice of providing certain therapy management services and assistance to financially needy Medicare beneficiaries undergoing medical treatment for certain diseases. The OIG held that although the arrangement could potentially generate prohibited remuneration under the Anti-Kickback Statute, it would not impose administrative sanctions on the organization in connection with the arrangement.

The organization which requested the advisory opinion, is a non-profit tax-exempt charitable organization dedicated to providing financial assistance and certain therapy management services to financially needy patients undergoing medical treatment for certain diseases. For several years, the organization had limited its assistance to patients with private health insurance. However, the organization is now seeking to

expand this program to include financially needy Medicare beneficiaries. The organization operated its program to assist financially needy patients with any of several diseases (the “Funded Diseases”) that require therapy with certain types of medications (the “Specialty Therapeutics”). Medicare beneficiaries qualify for help from the organization if they meet certain financial criteria, are diagnosed with a Funded Disease and are undergoing treatment with a Specialty Therapeutic. Once patients are accepted into the program, the organization provides both financial assistance and therapy management services. The patients enroll in the program under the care of a physician with a treatment regimen in place at the time they apply to the organization for assistance. The organization certified to the OIG that its staff does not refer applicants to, recommend, or arrange for the use of any particular provider, practitioner, supplier or product. The patients have complete freedom in regard to their choice of providers, practitioners, suppliers and products. The organization’s funding is provided by individual donors, corporations and foundations and includes donations from manufacturers of these Specialty Therapeutics, pharmacies that dispense the Specialty Therapeutics, infusion companies that administer the Specialty Therapeutics, and by suppliers of the types of services used by patients that the organization assists. The organization stated to the OIG that no donor, or affiliate of any donor, exerts any direct or indirect influence or control over the organization or its program. The organization does not supply donors with any individual patient information. Furthermore, the organization’s reports to donors do not contain any information that would enable a donor to correlate the amount or frequency of its donations with the number or medical condition of patients that use its products or services, or the volume of those products or services.

The organization requested an advisory opinion from the OIG over concern that its program could violate the Anti-Kickback Statute. The Anti-Kickback Statute (“Medicare and Medicaid Patient Protection Act of 1987” as amended 42 U.S.C. § 1320a-7b) generally provides for criminal penalties for directly or indirectly, knowingly and willfully offering, paying for, soliciting or receiving remuneration of any kind in order to induce business (i.e. referrals) reimbursable under federal or state health care programs, including Medicare and Medicaid. The Anti-Kickback Statute defines remuneration as anything of value. Remuneration could include valuable gifts, waivers of deductibles or co-pays, or anything else that possesses monetary value. The concern for liability under the Anti-Kickback Statute with respect to the proposed arrangement set forth in the advisory opinion, pertains to the source of donations to the program. Nevertheless, in its advisory opinion, the OIG stated that, “(i)ndustry stake holders can effectively contribute to the health care safety net for financially needy Medicare beneficiaries by contributing to independent, bona fide charitable assistance programs.” The OIG stated that under properly constructed programs, such donations raise few, if any, concerns under the Anti-Kickback Statute.

The OIG concluded that the program proposed by the non-profit tax-exempt charitable organization posed minimal risk that donor contributions would improperly influence referrals by the organization. The OIG set forth several factors in support of its conclusion. First, under the program, no donor or affiliate of any donor exerts direct or indirect control over the organization or its program. Second, the organization awards assistance in a truly independent manner that severs any link between donors and beneficiaries. Third, the organization awards assistance without regard to any donor’s interest and without regard to the applicant’s choice of provider, practitioner, supplier, or product. Fourth, the organization provides assistance based upon a reasonable, verifiable, and uniform measure of financial need as applied in a consistent manner. Fifth, the organization does not provide donors with any data that would facilitate the donor in correlating the amount or frequency of its donations with the amount or frequency of the use of its products or services. Finally, the fact that the organization permits donors to earmark donations for particular Funded Diseases should not, on the facts presented, significantly raise the risk of use. In particular, the organization has certified that no donor, or affiliate of any donor, directly or indirectly influences the identification of the Funded Diseases. As a result of these factors, the OIG concluded that although it is possible that the program could potentially generate

prohibited remuneration under the Anti-Kickback Statute, the OIG would not impose administrative sanctions on the organization.

## **President Bush Issues Executive Order Promoting High Quality Health Care**

On August 22, 2006, President George W. Bush signed an Executive Order to promote quality and efficient health care in Federal Government administered or sponsored health care programs. The purpose of the Executive Order is to ensure that health care programs, administered or sponsored by the Federal Government, promote quality and efficient delivery of health care through the use of health information technology, transparency regarding healthcare quality and price, and better incentives for program beneficiaries, enrollees and providers.

The Executive Order requires agencies of the Federal Government that administer or sponsor a federal health care program, to utilize, where available, health information technology systems and products that recognize interoperability standards. In this regard, each agency shall be required, in contracts or agreements with health care providers, health plans or health insurance issues, that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall utilize, where available, health information technology systems and products that meet recognized interoperability standards.

The Executive Order also requires each agency of the Federal Government that administers or sponsors a federal health care program, to implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of a federal health care program. Each agency shall also be required to make available to the beneficiaries or enrollees of federal health care programs, the prices that it, its health insurance issuers, or its health insurance plans pay for procedures to providers in the health care program with which the agency, issuer, or plan contracts. Finally, the Executive Order requires each agency to develop and identify, for beneficiaries, enrollees and providers, approaches that encourage and facilitate the provision and receipt of high-quality and efficient health care. The Executive Order acknowledges that such approaches may include pay-for-performance models of reimbursement.

Agencies are required to comply with the requirements of the Executive Order by January 1, 2007.

---

This Newsletter is published by The Rogers Law Firm to keep its clients informed of developments in health law. The Newsletter should not be construed or relied upon as legal advice or legal opinion on any specific facts or circumstances. If you have any questions or concerns regarding the articles contained in the Newsletter or would like legal advice or legal opinion concerning a specific matter, please do not hesitate to contact any of the attorneys at The Rogers Law Firm, at (617) 723-1100.