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healthcare law alert

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CMS Proposes Additions to List of Hospital Acquired Conditions or "Never Events"

By Sammi L. Renken

"Never Events" are conditions that have been found by the Centers for Medicare & Medicaid Services (CMS) and/or the National Quality Forum (NQF) to be preventable errors that are hospital acquired. In other words, these conditions are not present at the time of admission and should not occur but for an error by the hospital staff. On April 14, 2008, the Centers for Medicare & Medicaid Services (CMS) announced a proposed rule that would update payment policies and rates beginning with discharges on or after October 1, 2008. CMS has also recently proposed selecting nine additional categories of hospital acquired conditions. Section 5001(c) of the Deficit Reduction Act of 2005 required the Secretary of the Department of Health and Human Services to select at least two conditions that are:

(1) high cost, high volume, or both
(2) identified through ICD-9-CM coding as a compli cating condition that when present as a secondary diagnosis at discharge results in payment at a higher MS-DRG;
(3) and, that are reasonably preventable through ap plication of evidence-based guidelines. (CMS Medicare Fact Sheet – April 14, 2008).

Last year, CMS selected eight conditions that qualify as Never Events which were:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood incompatibility
- Stage III & IV Pressure Ulcers
- Falls and Trauma (Fractures, Intracranial Injuries, Crushing Injuries, Burns)
- Catheter Associated Urinary Tract Infection
- Vascular Catheter Associated Infection, and
- Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft

This year, CMS is proposing to add nine additional

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"Never Events"

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categories including:

- Surgical Site Infections following certain elective procedures
- Legionnaires' Disease
- Hypoglycemic Coma
- Iatrogenic Pneumothorax
- Delirium
- Ventilator Associated Pneumonia
- Deep Vein Thrombosis/ Pulmonary Embolism
- Staphylococcus Aureus Septicemia
- Clostridium Difficile Associated Disease

The additional categories are still under review. The final rule on these additional categories is expected to be published on August 1, 2008.

The total impact of CMS finding that a hospital patient has one of these Hospital Acquired Conditions or Never Events is still to be determined. However, CMS has stated that "beginning October 1, 2008, Medicare will no longer pay at a higher weighted MS-DRG for these conditions or any of the additional nine conditions" that have been proposed. (CMS Medicare Fact Sheet – April 14, 2008). Without a doubt, the Never Events will pose a serious financial problem to many hospitals should those conditions be found not to be covered by Medicare or Medicaid in the future. In addition, should private insurers begin to enact the same policies, the financial loss will be even greater. One key area will be ensuring that there is strict documentation of all possible conditions that could fall within these categories on admission. If the condition is not hospital acquired, but rather the patient arrives with it present on admission, then it is not a Never Event. We will continue to report any upcoming news regarding these regulations and the final rules expected to be issued this summer. ■

Current Trends in the Utility of Binding Arbitration Agreements

By Bradley D. Price

Nursing homes and other managed-care facilities are dealing with an all-too-familiar challenge: the allocation of resources between caring for their patients and maintaining a reserve for potential future litigation. Recent legal developments, however, may help these entities confront this challenge. Binding arbitration clauses are becoming an increasingly important component of nursing-home policies because, if enforced, these clauses allow these facilities to limit their liability exposure, thereby freeing up money and resources to better care for their patients. Recent case law suggests that there is a trend, at least among federal courts, to enforce these binding arbitration clauses.

Federal policy has long favored resolving legal disputes through binding arbitration, which can significantly limit the time and cost associated with traditional litigation. *See* Federal Arbitration Act, 9 U.S.C. § 1 et seq. (2000) (first passed in 1925). Admittedly, the binding arbitration process has its critics. Most of them are members of the plaintiff's bar, but even some Arbitration Associations disfavor certain types of arbitration agreements that they believe are unfair or inequitable. *See* Nathan Koppel, *Nursing Homes, in Bid to Cut Costs, Prod Patients to Forgo Lawsuits*, WALL ST. J., Apr. 11, 2008, at A1. Recently, the United States Supreme Court affirmed Congress's desire to "replace judicial indisposition to arbitration with a 'national policy favoring [it] and plac[ing] arbitration agreements on equal footing with all other contracts.'" *Hall Street Assoc., LLC v. Mattel, Inc.,* (*quoting Buckeye Check Cashing, Inc. v. Cardegna*).

This landmark case solidified the legitimacy of resolving disputes by arbitration in the eyes of the judiciary. However, it also made clear that the judiciary will impose limits on the terms of binding arbitration agreements. The case held that parties to such agreements are not free to alter the scope of review of certain arbitration awards. *Hall Street*, (holding that the "statutory grounds [under §§ 9-11 of the Federal Arbitration Act] for prompt vacatur and modification . . . are exclusive" and may not be supplemented by contract). Specifically, the Federal Arbitration Act provides relatively narrow grounds upon which an arbitration award can be disturbed, including, among other factors, "corruption, fraud . . . undue means . . . evident partiality . . . [or] evident miscalculation." 9 U.S.C. § 10-11 (2000).

Generally, nursing homes are governed by state statutes and regulations, and most disputes regarding these facilities occur in state court. However, arbitration agreements between the facilities and their residents will often be governed by the Federal Arbitration Act. *See Southland Corp. v. Keating* (noting the Federal Arbitration Act's applicability to disputes in state court). These facilities engage in "commerce" under the definition of the Act, thereby making their arbitration agreements the subject of federal jurisdiction pursuant to this statute. *Hall Street* (noting that the "Act . . . bestow[s] no federal jurisdiction but rather requir[es] an independent jurisdictional basis"). Therefore, the holdings of *Hall Street* will govern arbitration agreements entered into by healthcare entities.

Despite the federal trend noted above, the Illinois Appellate court in *Carter v. SSC Odin Operating Co., LLC* recently questioned the enforceability of arbitration agreements, noting that such agreements may not comport with public policy in Illinois. *Carter* rejected a defendant nursing home's motion to com-

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Binding Arbitration Agreements

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pel arbitration based upon a binding arbitration agreement between the parties. *Id*. The court rejected the defendant's claim that the Illinois Nursing Home Care Act's prohibition against waiving the right to a jury trial specifically targeted arbitration agreements and was therefore preempted by the Federal Arbitration Act. *Id*. at 11-12 (*discussing Doctor's Associates, Inc. v. Casarotto*). Rather, the *Carter* court construed the language of the Nursing Home Care Act broadly as though directed toward "contractual agreements generally." *Id*. The court therefore held that the Nursing Home Care Act did not conflict with the Federal Arbitration Act. Further, it found that because these Acts did not conflict, public policy considerations were an appropriate ground upon which a court could prevent the enforcement of a binding arbitration agreement. *Id*. It is important to note that the *Carter* decision is based upon a state appellate court's interpretation of federal law, and is thus not necessarily the final word on the matter. Nonetheless, the *Carter* case should underscore the importance of a carefully-worded arbitration agreement.

Nursing homes and other managed-care facilities should take care in drafting their arbitration agreements and give serious thought to the way a court might view the public policies implicated by the agreements' wording and presentation to residents. Facilities should not assume the mere inclusion of an arbitration agreement in their contracts will ensure enforceability of that agreement. Further, it is important to recognize that the Federal Arbitration Act will often control any review of an award under an arbitration agreement, thereby limiting the review process that either party may pursue. While some local obstacles currently exist to the unbridled use of binding arbitration agreements, the current trend seems to favor more pervasive enforcement of carefully-crafted arbitration agreements in the healthcare context, which could ultimately aid nursing homes in more effectively allocating resources and serving their residents. ■

10 Years Later, Section 2-622, 90 Day Extension Rule Invalidated & Defendants Stripped of a Valuable Defense

By Matthew L. Johnson & Erin Blake

A recent Illinois Supreme Court decision invalidated a provision in Section 2-622 (a)(2) of the Code of Civil Procedure established by the Civil Justice Reform Amendments of 1995. Section 2-622 (a)(2) stated that the plaintiff was precluded from obtaining a 90 day extension to file a certificate of merit, if the plaintiff previously voluntarily dismissed the same or substantially the same cause of action. In the 1997 case of *Best v. Taylor Machine Works*, the Civil Justice Reform Amendments were invalidated because the core provisions were found substantively unconstitutional; however, the Court held that the General Assembly was free to reenact whatever provisions it deemed appropriate. In May 1998, Public Act 90-579 was passed adding language to Section 2-622(a)(1) including naprapaths to the list of covered professionals, as well as preserving the original language of the 1995 Amendments providing the defense with an action for dismissal if the plaintiff failed to attach a certificate of merit to a refiled complaint.

Numerous cases had been decided by the Illinois Appellate Courts since Public Act 90-579 was passed, including *Cargill v. Czelatdko*, where the Appellate Court held that if a 2-622 report was not attached to a filed complaint, the plaintiff had to attach an affidavit indicating that he had not previously voluntarily dismissed an action based upon the same or substantially the same acts. The Cargill case also held that in a refiled malpractice case, the court had no discretion to waive the affidavit requirement; thus, failure to comply mandated dismissal of the complaint with prejudice.

Yet, on June 19, 2008, 10 years after Public Act 90-579 was issued, the Supreme Court in *O'Casek v. Children's Home and Aid Society of Illinois*, held that there is to be no limitation on obtaining a 90-day extension to file a certificate of merit in a refiled action. Specifically, the circuit court granted the defendant's dismissal motion after it was shown that the plaintiff failed to attach a certificate of merit to her refiled complaint.

The plaintiff then appealed and the Illinois Appellate Court held that Public Act 90-579 was invalid, the Cargill decision was erroneous, and dismissal of the plaintiff's case was to be reversed. The Supreme Court of Illinois granted a review to determine the issue of whether Public Act 90-579 effectively re-enacted the invalidated provision of the Civil Reforms of 1995 or if it resurrected the pre-1995, 2-622 statutory language, where the affidavit option to defer compliance with the certification requirement was not limited to situations where there had been no prior voluntary dismissal. In a split decision, the Supreme Court held that malpractice complaints are governed by the pre-1995 version of Section 2-622, as amended only with the addition of naprapath language found in Public Act 90-579. The pre-1995 version of 2-622(a)(2) contains no limitation on obtaining a 90 day extension to file a certificate of error in a refiled action; therefore, the judgment of the Appellate court was affirmed.

Therefore, based on this recent Supreme Court decision, dismissal of a plaintiff's refiled complaint, based on failure to comply with the requirement of immediately attaching a certificate of merit, no longer is an option for the defense. ■

Law Alert Update

Admissibility of Medical Bills – Amount Paid No Longer Admissible

By Sammi L. Renken

The Illinois Supreme Court recently reviewed whether the Trial Court erred in reducing the jury's award of medical expenses to the amount actually paid by Medicaid and Medicare. This issue was previously addressed but the Court states was not resolved in *Arthur v. Catour*, 216 Ill.2d 72, 833 N.E.2d 847 (2005). The trial court, over defendant's objection, allowed plaintiff to submit the total amount billed by Medicare and Medicaid. The jury then awarded the full amount of medical bills. Post-verdict, the trial court granted defendant's motion to reduce plaintiff's medical expenses to the amount actually paid by Medicare and Medicaid. The plaintiff then appealed and argued that the Trial Court's order violated the collateral source rule and was contrary to the decision in *Arthur v. Catour*. The Third District Appellate Court on the evidentiary question held that allowing the plaintiff to submit initially the total amount billed was appropriate, but on the damages question, the Third District held that the defendant was not entitled to a set offer of reduction of the award to the amount actually paid by Medicare. The Illinois Supreme Court has now decided the issue and has taken the "reasonable value approach" which means that all plaintiffs are entitled to seek to recover the full reasonable value of their medical expenses which the Court interprets as an amount that is not limited to the amount actually paid. The Court specifically states that the defendants are free to cross-examine witnesses that a plaintiff might call to establish reasonableness and even to call their own witnesses as to the reasonable value of services, but the defendants may not introduce evidence that the plaintiff's bills were settled for a lesser amount. The Supreme Court reversed the Appellate Court's judgment upholding the Trial Court's reduction of plaintiff's medical expenses. The case was remanded to the Circuit Court for further proceedings. *Wills v. Foster*, Docket No. 104538, 2008 Ill.Lexis 629, opinion filed June 19, 2008. ■

Upcoming Seminar

"Never Events" Seminar - Fall 2008

"Never Events" are conditions that have been found by the Centers for Medicare & Medicaid Services (CMS) to be preventable errors that are hospital acquired. CMS recently proposed an additional nine categories of hospital-acquired conditions. Do you know what these nine additional categories are and how they could affect you and your patients? Johnson & Bell, Ltd. will be hosting a seminar on September 30, 2008, to discuss the proposed "Never Events" and the impact of these new regulations. If you are interested in attending the seminar, please send an email to starbuckk@jbltd.com or call Kathy Starbuck at 312.984.0273. ■

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