Drinker Biddle presents the inaugural issue of our quarterly e-zine, Health Law Beat, which will provide you with articles regarding pertinent health law issues affecting the health care industry. If you have any questions, please click here to contact any member of the Drinker Biddle Health Law Practice Group.

Health Law Beat

The HITECH Act & Beyond: Funding for the Adoption of Health Care IT

by Jeffrey T. Ganiban

Under the stimulus package signed into law by President Barack Obama on February 17, 2009, $19 billion has been appropriated to fund the promotion of a national infrastructure for the electronic exchange of health information and the widespread adoption of electronic health record (EHR) technology. The $19 billion includes $2 billion appropriated under the Health Information Technology for Economic and Clinical Health (HITECH) Act. These funds are to be spent by the Department of Health and Human Services (HHS) to fund private and public/private initiatives to promote the adoption of health information technology. Congress has instructed HHS to expend these funds “as quickly as possible consistent with prudent management.”

The remaining $17 billion is in the form of incentive payments to be made to “eligible professionals” and hospitals that are “meaningful users” of health information technology. These

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Negligent Credentialing: Illinois the Latest State to Recognize the Tort

by John J. D’Attomo

The evolving tort of “negligent credentialing” presents yet another potential source of liability for hospitals arising from poor patient outcomes. Hospital administrators should be aware of the potential serious consequences of failing to ensure that all physician-credentialing decisions are made consistent with the hospital bylaws, medical staff bylaws and applicable accreditation standards.

The Legal Theory Underlying Negligent Credentialing

Hospitals owe a duty of care to their patients to exercise reasonable care in the management and operation of the hospital. This duty exists separate and apart from the duty of care owed by physicians and other medical professionals rendering medical services at the hospital. A hospital’s failure to exercise reasonable care with respect to the care of its patients can give rise to a claim of “institutional negligence.”

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Significant technological advancements, such as videoconferencing, computer and communications technologies, now allow physicians and other providers to treat patients not located anywhere near them and nearly anywhere in the world. Telemedicine – essentially care at a distance – can take the place of face-to-face encounters for consultations, office visits and other health care services, and allows many patients access to care they otherwise would not receive. In this way, telemedicine is truly the new frontier in medicine.

Regulatory and reimbursement obstacles limit the number of patients that can avail themselves of telehealth services. While telehealth treatment is held to the same standard of care as traditional face-to-face interactions between patients and physicians, issues such as credentialing present critical challenges to the full realization of telehealth’s potential.

Hospitals have a legal duty to evaluate the competence of physicians who administer health care services to their patients. Credentialing is founded on the principle that hospitals are responsible for ensuring the highest quality of care possible for patients. Medical care facilities take steps to verify their health care provider’s proficiency through the collection, verification and evaluation of data relevant to the practitioner’s professional performance. Once the practitioner is credentialed, the hospital will take further steps to assess the practitioner’s competence in a specific area of patient care, through a process known as privileging.

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A federal appeals court has reversed a damages award of $33 million against a hospital and certain physicians arising from a temporary restriction of a cardiologist’s cath lab privileges. The decision of the U.S. Court of Appeals for the Fifth Circuit in Poliner v. Texas Health Systems reaffirms the principle that participants involved in peer review proceedings are immune from damages under the federal Health Care Quality Improvement Act (HCQIA) when certain requirements are satisfied. The decision also makes clear that an objective standard applies when assessing the reasonableness of the peer reviewer’s actions and that the subjective motivations of the peer review participants are irrelevant to the immunity question.

The Abeyance of Plaintiff’s Cath Lab Privileges

In May 1998, a patient presented at the emergency room of Presbyterian Hospital in Dallas, Texas with a heart attack. The patient was referred to plaintiff, an interventional cardiologist, with a solo practice at Presbyterian Hospital. Plaintiff performed diagnostic tests on the patient but failed to detect a completely blocked artery.

Following this incident, the chairman of the internal medicine department at Presbyterian Hospital, Dr. Knochel, sought an “abeyance,” i.e., a temporary restriction, of plaintiff’s cath lab privileges pending an investigation. Dr. Knochel advised plaintiff that, pursuant to the hospital’s medical staff bylaws, his privileges would be suspended if he did not agree to the abeyance. Plaintiff consequently signed the abeyance request on May 14, 1998.

Thereafter, an ad hoc committee reviewed a sample of the cardiologist’s cases and concluded that he had rendered substandard care in more than half of the cases reviewed. Based on the ad hoc committee’s report, Dr. Knochel requested that plaintiff consent to an extension of the abeyance to permit further investigation, again advising that the cardiologist’s privileges would be suspended if he did not agree to the abeyance. Plaintiff signed the extension request. Following further investigation, and based on the recommendation of the Internal Medicine Advisory Committee, Dr. Knochel suspended plaintiff’s cath lab and echocardiography privileges on June 12, 1998. Approximately five months later, a hearing committee upheld the suspension but directed that the cardiologist’s privileges be reinstated with certain conditions.

What Happens if the Provider Fails to File Correct and Accurate Claims?

Federal law permits Medicare to recover its conditional payments. Providers can also be fined for knowingly, willfully and repeatedly providing inaccurate information relating to the existence of other health insurance or coverage.

What is the Provider’s Role?

Providers should obtain billing information prior to furnishing services and submit any MSP information to the appropriate Medicare contractor. Providers may also want to ask the beneficiary if he or she is taking legal action in conjunction with the services performed. You can obtain a CMS questionnaire that lists the appropriate questions.

Have There Been Any New Developments Regarding MSP?

The recent SCHIP Extension Act requires insurers or third-party administrators of group health plans, and plan administrators or fiduciaries of employer-sponsored self-insured and self-administered group health plans, to report to the Department of Health and Human Services whether plans are primary to Medicare.

For more information about Medicare Secondary Payer issues, please click here.
incentive payments will commence in fiscal year 2011, and are phased out over a four-year period for hospitals and over five years for “eligible professionals.”

The key provisions of the HITECH Act include:

> $17 billion in incentive payments to Medicare and Medicaid hospitals and “eligible professionals” that become “meaningful users” of EHR technology. Payments for hospitals will be phased out over a four-year period, and over five years for “eligible professionals.” The formula for determining hospital payments involves a $2 million base payment adjusted by many factors, including annual Medicare discharges and inpatient days.

“Meaningful use” includes (1) electronic exchange of health information to improve the quality of care, such as promoting coordination of care; and (2) reporting on clinical quality measures (which will become more stringent over time);

> An appropriation of $2 billion to support regional and state initiatives that promote the adoption of EHR technology and best practices; and

> The formal establishment of the Office of the National Coordinator for Health Information Technology (HIT), and creation of the HIT Policy Committee and the HIT Standards Committee.

In addition to the $19 billion discussed above, the stimulus package includes significant funding for other health care related initiatives, including:

> $1.5 billion for grants for construction, renovation, equipment and acquisition of HIT systems for community health centers;

> $1 billion for wellness and prevention programs;

> $1 billion for grants or contracts to construct, renovate or repair existing nonfederal research facilities;

> $1.1 billion for comparative effectiveness research;

> $500 million for grants to community health centers;

> $500 million to expand training of primary care professionals;

> $360 million for construction of research facilities; and

> Improved privacy and security protections for health information as health IT usage increases. 

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Plaintiff Sues for Defamation and Other Claims

Plaintiff brought suit against Dr. Knochel, the hospital and other physicians involved in the peer review process, asserting claims under federal and state law, including claims for defamation. According to plaintiff, the defendants defamed him and destroyed his practice by labeling him a “dangerous doctor.” He also argued that he was forced to agree to the abeyance, which was in effect a summary suspension of his privileges, and that defendants failed to satisfy the requirements for a summary suspension under the medical staff bylaws. Finally, the cardiologist argued that the defendants were motivated by an intent to eliminate him as a competitive threat to the other cardiology groups at the hospital.

The defendants moved for summary judgment asserting, among other things, immunity under the HCQIA. The trial court concluded that the defendants were entitled to immunity for any damages resulting from the June 12 suspension order, but that an issue existed as to whether Dr. Knochel’s threat to summarily suspend the cardiologist’s privileges vitiated his consent to the abeyance. The court reasoned that, if he had not consented to the abeyance, the abeyance was in effect a summary suspension and called into question whether defendants satisfied the notice and hearing requirements of the HCQIA.

The case proceeded to trial and the jury found in favor of the cardiologist. Although he could demonstrate only some $10,000 in actual lost income, the jury awarded him more than $90 million in damages for defamation and $110 million in punitive damages. The trial judge later ordered a remittitur and reduced the award of damages to $33 million.

The HCQIA Confers Immunity for Each Peer Review Action

On appeal, the Fifth Circuit reversed the trial court judgment, finding that defendants were entitled to immunity from damages for both the abeyance and the suspension of plaintiff’s privileges. In reaching its decision, the Poliner court addressed the policy underlying the HCQIA and the statutory requirements for immunity.

In enacting the HCQIA, Congress sought to reduce the occurrence of medical malpractice and improve the quality of medical care. While concluding that peer review was an important component in achieving these goals, Congress “recognized that lawsuits for money damages dampened the willingness of people to participate in peer review.” Accordingly, Congress “granted limited immunity from suits for money damages to participants in professional peer review actions.” When the peer review action meets certain statutory requirements, the HCQIA provides that participants “shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.” Immunity under the HCQIA is limited to money damages; a plaintiff may seek injunctive and declaratory relief in appropriate cases.

The Four Requirements For HCQIA Immunity

The circuit court found that defendants satisfied the four requirements for immunity under the HCQIA. First, the peer review action was taken in the reasonable belief the action was in furtherance of quality health care. This standard is satisfied where the reviewers, with information available to them at the time, would have concluded that their action would restrict incompetent behavior or would protect patients. The court noted that the failure to diagnose the blocked artery was a critical error and that restricting plaintiff’s cath lab privileges during the investigation, and later extending the abeyance after receipt of the ad hoc committee report, was objectively reasonable.

In rejecting plaintiff’s claim that the defendants were seeking to eliminate him as a competitor of other cardiology groups, the court noted that the reasonableness of the peer reviewer’s actions is judged under an objective standard for purposes of the HCQIA. Stated differently, the subjective motivation of the peer review participants is irrelevant to the immunity question.
Second, the peer review action was taken after a reasonable effort to obtain the facts. The court noted that the peer review participants discussed the diagnostic error with the plaintiff, another physician involved in the care of the patient, the physician who discovered the diagnostic error, the director of the cath lab and the chief of cardiology. The diagnostic films were reviewed, as were certain of plaintiff’s other cases. With respect to the extension of the abeyance, Dr. Knochel relied on the ad hoc committee’s review of those other cases.

In concluding that the peer review action was taken after a reasonable effort to obtain the facts, the court noted that HCQIA immunity requires only a reasonable effort to obtain the facts, “not a perfect effort.” The court rejected plaintiff’s argument that a reasonable effort was lacking because defendants admitted that further investigation was required before his privileges could be summarily suspended under the medical staff bylaws. The court held that “HCQIA immunity is not coextensive with compliance with an individual hospital’s bylaws” and that failure to comply with hospital bylaws does not defeat HCQIA immunity.

Third, the peer review action complied with the HCQIA’s notice and hearing procedures. At the outset, the court noted that the HCQIA contains an exception to the standard notice and hearing procedures where the restriction on privileges is for not longer than 14 days during which time an investigation is being conducted to determine whether further action is necessary. The court found that the May 14 abeyance fell within this exception to the notice and hearing procedures.

With respect to the extension of the abeyance, the court concluded that it fell within the “emergency” provision of the HCQIA. The emergency provision allows for an immediate suspension or restriction of clinical privileges where the failure to take such action may result in an imminent danger to the health of any individual. Based on the ad hoc committee’s report that plaintiff rendered substandard care in more than half the cases reviewed and on the seriousness of the diagnostic error giving rise to the abeyance, the court found that the extension of the abeyance fell within the emergency provision in the HCQIA. Finally, with respect to the June 12 suspension, the court concluded that plaintiff received notice and a hearing adequate to satisfy the HCQIA.

In reaching its decision, the Poliner court noted that the HCQIA includes a presumption that a peer review action meets the standards for immunity unless the presumption is rebutted by a preponderance of the evidence. The court concluded that plaintiff not only failed to rebut the presumption that the peer review actions met the statutory standards, but that the evidence independently demonstrated that the peer review actions met the statutory standards.

Conclusion

The HCQIA confers peer review participants with immunity from damages when the statutory requirements are satisfied. Compliance with an individual hospital’s bylaws is not a prerequisite to immunity under the HCQIA. Rather, the relevant question is whether the peer review action complies with the statutory requirements under the HCQIA. As in Poliner, the allegation that defendants did not satisfy the requirements for a summary suspension of plaintiff’s privileges under the medical staff bylaws was immaterial. Similarly, the cardiologist’s allegation that defendants had anticompetitive motives was irrelevant to the question of immunity under the HCQIA. Poliner reaffirms that an objective standard applies when assessing the reasonableness of the peer reviewer’s actions.

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The doctrine of “negligent credentialing” has evolved from the theory of “institutional negligence.” Courts have recognized that an injured patient can assert a claim for negligent credentialing against the hospital that granted staff privileges to a physician who did not meet the requirements for staff privileges. The theory underlying this claim is that the hospital breached its duty of care in its management by granting privileges to an unqualified physician. In such cases, liability is founded on the duty of care the hospital owes to its patients, independent of any duty owed by the physician.

Illinois Recognizes Negligent Credentialing
With the Illinois Appellate Court’s decision in Frigo v. Silver Cross Hospital and Medical Center, Illinois has joined the growing number of states in adopting the doctrine of negligent credentialing. In Frigo, a jury awarded $7.7 million to a patient whose foot was amputated as a result of a negligent surgery performed by a podiatrist. The evidence showed that the hospital granted category II surgical credentials to the podiatrist even though he never completed a 12-month podiatric surgical residency and was not board certified as required by the hospital’s bylaws and hospital accreditation standards. The hospital mistakenly believed that the podiatrist qualified for category II surgical privileges based on a “grandfather clause” in certain of its rules. In support of her negligence claim, plaintiff alleged that the hospital breached its duty of care in the management and operation of the hospital by granting the podiatrist privileges without verifying that he satisfied the hospital’s own credentialing requirements.

In affirming the jury’s verdict against the hospital, the court set forth the elements necessary to prevail on a negligent credentialing claim. First, the plaintiff must prove that the hospital failed to exercise reasonable care in granting staff privileges to the physician whose treatment gave rise to the underlying malpractice claim. Second, the plaintiff must prove that the physician breached the applicable standard of care while rendering medical care pursuant to the negligently granted staff privileges. Finally, the plaintiff must prove that the hospital’s negligence in granting privileges was a proximate cause of the plaintiff’s injuries.

A New Variation on Established Principles
In recognizing the cause of action for negligent credentialing, the Illinois Appellate Court observed that the principles involved “are not new.” The court noted that Illinois decisions from more than 40 years ago acknowledged that hospitals owe an independent duty of care to their patients and could be liable for “institutional negligence” if they breach that duty. See Darling v. Charleston Community Memorial Hospital.

In Darling, plaintiff was treated at the defendant hospital for a broken leg. The treatment included placing his leg in a cast. During his hospital stay, the hospital staff failed to notice that the circulation in plaintiff’s leg was constricted leading to the amputation of plaintiff’s leg below the knee. In addition to suing the treating physician, plaintiff sued the hospital alleging, among other things, that the hospital nurses failed to monitor the circulation in his leg as frequently as necessary to recognize the progressively gangrenous condition of his leg. Plaintiff alleged that the hospital had a duty to ensure that adequate monitoring procedures were followed and that the hospital failed to satisfy its duty. The Illinois Supreme Court upheld the jury’s verdict against the hospital recognizing that the hospital could be liable for negligence, i.e., “institutional
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negligence,” independent of any negligence of the treating physician.

The Underlying Theory of Institutional Negligence Continues to Evolve

Although not involving negligent credentialing, a more recent decision from the Illinois Appellate Court extended the doctrine of institutional negligence to impose liability on a hospital even where the treating physician was not found negligent. See Longnecker v. Loyola.3 In that case, plaintiff sued the hospital after her husband died following a heart transplant, alleging that the surgeon who acted as the “harvesting” surgeon for the donor heart committed professional negligence by failing to properly test and inspect the donor heart. Plaintiff further alleged that the hospital committed institutional negligence by failing to ensure that the harvesting physician understood that his duties as part of the transplant team included evaluating the heart for transplantation, not simply harvesting the donor heart. At trial, the jury found in favor of the surgeon on the professional negligence claim, but found against the defendant hospital on the claim of institutional negligence and awarded the plaintiff $2.7 million. On appeal, the court held that the defendant hospital could be liable for institutional negligence even where the defendant surgeon was found not negligent.

Conclusion

An increasing number of courts have recognized “negligent credentialing” as a common law cause of action. Claims of negligent credentialing often implicate issues concerning hospital bylaws, medical staff bylaws, hospital accreditation standards, credentialing procedures and the peer review process. Hospitals should be aware that every medical malpractice case arising from medical care rendered at the hospital by a physician with staff privileges may potentially lead to scrutiny of the hospital’s credentialing procedures. Hospitals are well advised to review their credentialing procedures to ensure that all credentialing decisions have been made, and will be made, in compliance with the hospital bylaws, medical staff bylaws and applicable accreditation standards. Recent court decisions vividly illustrate that a hospital’s failure to adhere to proper credentialing procedures may have serious consequences. HLB

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The Telemedicine Conundrum: How to Credential Telehealth Practitioners

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Telehealth practitioners, unlike their “brick and mortar” counterparts, do not reside at one specific hospital or institution. A practitioner can be located in what is referred to as a “hub” facility, or main practicing location, and administer health care services to patients anywhere in the country in multiple “spoke” hospitals in just one day. This hub-and-spoke structure creates the issue: which hospital is responsible for credentialing the practitioner – the distance site receiving the telemedicine consult or the originating site giving the assistance?

The structure has created an administrative and legal conundrum: duly credentialed practitioners at one provider may not be able to provide service to a patient at a remote location because that provider is not properly credentialed at the site in which the patient is physically located. One potential solution is to have a separate entity that approves credentials of telehealth care providers. In 2001, the Joint Commission (JC), formerly known as the Joint Commission on Accreditation of Healthcare Organizations, introduced standards for institutional credentialing of telehealth providers. Under these standards, a physician credentialed in any JC facility would be permitted to provide telehealth services in another JC facility. JC allows the facility where the patient is being treated to credential the treating physician in two ways: (1) the treating facility could fully credential the physician based on their own facility’s standards, or (2) the treating facility could accept the credentials of the treating physician based on the fact that the remote institution is JC-certified. JC standards for credentialing are based on patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.3

While this may seem like a practicable solution, the Centers for Medicare and Medicaid Services (CMS) has weighed in, concluding that a telehealth physician’s compliance with JC credentialing rules is not sufficient to ensure compliance with the Medicare Conditions of Participation providers must meet in order to be Medicare participants. CMS has stated that any physician who provides a “medical level of care” should be credentialed by the facility providing the care. The result is that telehealth providers might be forced to be credentialed by multiple hospitals nationwide – an administrative nightmare for hospitals and providers.

Many in the telehealth field have expressed concern that CMS’s decision may effectively chill the advancement of telemedicine, a prospect that could lead to significantly decreased quality of care in rural and underserved areas, among others. In response to this concern, the Center for Telehealth and e-Health Law (CTeL), a nonprofit research institute, has compiled an assessment to gauge the impact of the CMS policy. The findings of this informational assessment will be published at www.telehealthlawcenter.org.4 In the meantime, physicians and hospitals interested in providing telehealth services must continue dealing with the administrative stumbling blocks that make it difficult to provide these services, potentially depriving many patients – especially those in rural and underserved areas – of critical care.

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3 Joint Commission on Accreditation of Healthcare Organizations, Hospital Accreditation Standards, 202-203 (2009).

4 CTeL urges institutions receiving or providing telehealth services that require the credentialing of physicians who provide inpatient or outpatient clinical services be represented in this assessment.
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