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2006 Legislative Update

The Connecticut General Assembly convened on February 8, 2006 and adjourned on May 3, 2006. Despite being a short session, the legislature managed to pass several items impacting the health care industry. The following is a brief summary of some of the more significant Connecticut health care legislation enacted during the 2006 regular legislative session.

CHANGES TO LAWS REGARDING THE OFFICE OF HEALTH CARE ACCESS *Public Act 06-28 Increases Capital Expenditure Thresholds Under CON Laws*

Effective July 1, 2006, the Certificate of Need ("CON") capital expenditure thresholds will be increased from \$1 million to \$3 million. Public Act 06-28 also increases the CON threshold for the purchase, lease or acceptance of donation of major medical equipment requiring a capital expenditure from \$400,000 to \$3 million. The likely effect of these revisions will be to decrease the number of CON applications presented to the Office of Health Care Access ("OHCA") for review by eliminating the administrative approval process for capital expenditures below the new threshold amounts.

In addition to increasing the capital expenditure thresholds, Public Act 06-28 increases the threshold amount at which a CON is required for replacement of certain equipment. Presently, if a facility, institution or provider has previously obtained a CON for major medical or imaging equipment and wants to replace the equipment, OHCA can waive the CON requirements if the replacement value or expenditure for the replacement is not more than the original cost plus ten percent for each twelve-month period that has elapsed since the original CON and the equipment is valued at less than \$2 million. Public Act 06-64, also effective July 1, 2006, eliminates the requirement that the replacement value or expenditure not exceed the original cost plus ten percent for each twelve-month period that has elapsed since the original CON. Public Act 06-28 then increases the equipment value threshold from \$2 million to \$3 million. These public acts result in a simple \$3 million threshold before the replacement of major medical or imaging equipment requires a CON.

The current law also allows OHCA to impose civil monetary penalties of \$1,000 per day against

any person, facility or institution who fails to report their ownership, operation or acquisition of major medical equipment costing over \$400,000 or scanning equipment, cineangiography equipment, a linear accelerator or other similar equipment utilizing technology that is developed or introduced into the state on or after October 1, 2005, or such other data or information as required by law within certain prescribed time periods. Public Act 06-28 increases the minimum value of major medical equipment necessary to trigger the reporting requirement from \$400,000 to \$3 million.

Last year, the Connecticut legislature eliminated the \$400,000 capital expenditure threshold for acquisition of a CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. As a result, CON approval is required to purchase, lease or accept donation of such equipment regardless of its cost or value. However, the legislation contained an exemption from the CON requirements for facilities, institutions or providers who purchased before July 1, 2005 a CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator valued at less than \$400,000. Public Act 06-28 amends that exemption by requiring such equipment to also be in active operation on or before July 1, 2006 in order to avoid the CON process. Such equipment put into operation after July 1, 2006 will require CON approval regardless of its value or date of purchase.

Public Act 06-64 Modifies Certificate of Need Exemption for Certain Nonprofit Entities

Under current law, a CON exemption is available to any nonprofit entity if: (i) the nonprofit entity is proposing a capital expenditure of not more than \$1 million and the expenditure does not in fact exceed \$1 million; (ii) the activity meets a specific service need identified by a state agency or department and is confirmed as a current need by OHCA; and (iii) the state agency or department that has identified a specific need confirms, in writing, to OHCA that (A) the agency or department has identified a specific need with a detailed description of that need and the belief that the need continues to exist, (B) the activity in question meets all or part of the identified need and specifies how much of that need the proposal meets, (C) in the case of relocation of services, the agency or department has determined that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, (D) in the case of transfer of ownership or control, the agency or department has investigated the proposed change and the person or entity requesting the change has determined that the change would be in the best interest of the state and the patients or clients, and (E) the activity will be cost-effective and well managed. The current exemption does not apply to nonprofit entities proposing to terminate a service or facility.

Effective July 1, 2006, Public Act 06-64 limits this CON exemption to only those nonprofit entities under contract with a state agency or department at the time the exemption is requested. In addition, Public Act 06-64 changes the CON exemption to impose additional requirements if the nonprofit entity wishes to relocate services. Specifically, the new law requires the state agency or department that is identifying the specific service need and confirming such need in writing to OHCA, to be the state agency or department with which the nonprofit is under contract. The new law also requires that in the case of relocation of services, OHCA, in addition to the agency or department identifying the need, must determine that the needs of the area previously served will continue to be met in a better or satisfactory manner. With respect to the termination of a service or facility, OHCA will now allow the use of the exemption by a nonprofit entity under contract with a state agency or department but only if such state agency or department confirms in writing to OHCA that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how this is to be done and OHCA agrees.

SCOPE OF PRACTICE

Public Act 06-110 Increases Supervision of Physician Assistants ("PAs") Outside of Hospital Settings and Clarifies Requirements of the Supervising Physician

Under current law, all PAs must have a clearly identified supervising physician who is registered with the Department of Public Health ("DPH"). The supervising physician assumes responsibility for the supervision of services rendered by the PA. The new law maintains the current requirements for physician supervision of PAs in hospital settings. Specifically, in hospitals, the supervising physician must personally review the PA's practice at least weekly or more frequently as needed to ensure quality care.

Effective October 1, 2006, Public Act 06-110 will require that in settings other than hospitals: (i) the supervising physician's review be done through a face-to-face meeting with the PA, at least weekly or more frequently as necessary to ensure quality of care, at a facility or location where the PA or supervising physician practices and (ii) the supervising physician must document in writing the regular review of charts and records of the PA at the facility or practice location of the PA or supervising physician. The changes made by the new law also clarify that a physician does not need to be on site when services are provided by the PA, but that the supervising physician must be continuously available for direct communications (e.g. radio or telephone). Lastly, the new law specifies that, in any setting, a physician designated as the PA's alternate supervising physician in the absence of his or her regular supervising physician must be registered with DPH.

Public Act 06-169 Expands Advanced Practice Registered Nurse ("APRN") Prescriptive Authority

Effective October 1, 2006, Public Act 06-169 will permit APRNs to (i) dispense medical therapeutics and corrective measures and (ii) request, sign for, receive and dispense professional samples in all health care settings. Currently, APRNs are only permitted to dispense medical therapeutics and corrective measures in certain institutional settings (e.g. hospitals) and are only permitted to request, sign for, receive and dispense professional samples in non-institutional settings (e.g., a physician's office).

Public Act 06-195 Provides Nurse Midwives with More Independent Scope of Practice

Under current law, a clinical practice relationship between a nurse midwife and an obstetrician-gynecologist is required and must be based upon mutually agreed upon medical guidelines and written protocols containing a list of medications, devices and laboratory tests that may be prescribed, dispensed or administered by the nurse midwife.

Effective October 1, 2006, Public Act 06-195 expands the scope of practice for nurse midwives by removing the requirement for medical guidelines and written protocols. The new law will require that a clinical relationship between a nurse midwife and an obstetrician-gynecologist provide for consultation, collaborative management or referral as indicated by the health status of the patient. Rather than being controlled by guidelines and protocols, the practice of nurse-midwifery must now be consistent with the standards of care established by the American College of Nurse Midwives. Each nurse midwife must now provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the nurse midwife's scope of practice.

Public Act 06-160 Expands Podiatrists' Scope of Practice to Include Certain Nonsurgical Treatment of the Ankle

Currently, a podiatrist's scope of practice only allows diagnosis and treatment of ailments of the foot, including medical and surgical treatment, and administering and prescribing drugs incidental to such diagnosis and treatment. Effective October 1, 2006, Public Act 06-160 expands this scope of practice by allowing licensed podiatrists who are board qualified or certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine to engage in the medical and nonsurgical treatment of the ankle and its anatomical structures. This new scope of practice includes administering and prescribing drugs incidental to such treatment, as well as the nonsurgical treatment of local manifestations of systemic diseases as they appear on the ankle. The new law limits treatment of displaced ankle fractures to the initial diagnosis and the initial attempt at closed reduction at the time of presentation and prohibits treatment of tibial pilon fractures.

Public Act 06-160 also requires the Commissioner of DPH to convene a panel to develop protocols and recommendations to allow qualified podiatrists to perform surgery on the ankle. The Commissioner must report the panel's findings and recommendations to the Public Health Committee of the General Assembly by January 1, 2007.

Public Act 06-125 Permits Certain Physical Therapists to Treat Patients Without a Referral

Under current law, physical therapists can only evaluate and treat patients referred to them by a physician, podiatrist, naturopath, chiropractor, dentist, APRN or PA. Effective October 1, 2006, Public Act 06-125 permits certain licensed physical therapists to treat patients directly, without a referral, provided: (i) the physical therapist meets certain education and training qualifications, (ii) the patient discloses the name of their primary care physician or health care provider of record upon the initial visit for treatment without an oral or written referral, (iii) the physical therapist provides information to the patient regarding the need for consultation with the patient's health care provider regarding the patient's underlying medical condition if the condition is prolonged, does not improve in thirty (30) days or continues to require ongoing continuous treatment and (iv) the physical therapist refers the patient to an appropriate licensed practitioner if the patient does not demonstrate objective, measurable, functional improvement in the earlier of thirty (30) consecutive days or six (6) visits. The new law specifies that physical therapy does not include surgery, prescribing drugs or diagnosing disease, injury or illness.

The new law also allows certain licensed physical therapists to treat a workers' compensation injury or to perform Grade V spinal manipulation with an oral or written referral from an individual licensed in any state whose licensing requirements are approved by the Connecticut Department of Public Health and the appropriate examining board in Connecticut. Under current law, only licensed individuals from states with approved licensure requirements bordering Connecticut may make a referral.

INSURANCE COVERAGE AND FEE TRANSPARENCY

Public Act 06-180 Limits Copayments for Certain Imaging Services

Effective October 1, 2006, Public Act 06-180 limits the copayments that can be imposed on a person for magnetic resonance imaging ("MRI"), computed axial tomography ("CT"), and positron emission tomography ("PET") services performed in-network. Specifically, the new law will limit copayments for MRI and CT scans to no more than: (a) \$375 for all such services annually and (b) \$75 for each MRI or CT scan. The new law also limits copayments for PET scans to no more than (a) \$400 for all PET scans annually and (b) \$100 for each PET scan.

Public Act 06-38 Expands Breast Cancer Screening Insurance Coverage

Effective October 1, 2006, Public Act 06-38 will require health insurance policies to cover

comprehensive ultrasound screening if a mammogram shows certain heterogeneous or dense breast tissue or if a woman is considered at an increased breast cancer risk because of family history, her own prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or APRN.

Public Act 06-178 Establishes Transparency in Fee Schedules

Effective October 1, 2006, Public Act 06-178 establishes transparency in fee schedules established by managed care organizations ("MCOs") and preferred provider networks ("PPNs"). The new law requires that by October 1, 2007, each MCO and PPN must implement a procedure that will allow physicians under contract with the MCO or PPN to electronically view the amount the MCO or PPN pays the physician for the fifty (50) current procedural terminology ("CPT") codes the physician most commonly performs. The procedure must also permit a physician to view the CPT codes actually billed or intended to be billed by the physician, as long as the codes are within the physician's specialty or subspecialty. The fee information provided by the MCO or PPN is proprietary and confidential and unauthorized disclosure could result in penalties, including termination from the MCO or PPN network.

Public Act 06-108 Extends Reporting Period Coverage under Medical Malpractice Policies

Under current law, unlimited extended reporting coverage (e.g., tail coverage) must be provided by a malpractice insurer when (i) an insurer stops offering such policy in Connecticut for any reason and the insured is over the age of fifty-five (55) and has been insured by the insurer for the seven (7) consecutive years immediately preceding the discontinuance or (ii) the insured dies, becomes permanently disabled and unable to carry out his practice or retires permanently from practice. Effective October 1, 2006, Public Act 06-108 increases the age to sixty (60) years of age and reduces the number of years of consecutive coverage to five (5) years. The new law also removes the obligation of malpractice insurers to provide extended reporting coverage if the insured dies or becomes permanently disabled and provides for unlimited tail coverage with equivalent terms and conditions and with an aggregate liability limit at least equal to the aggregate liability limit specified in the policy.

NEW LICENSURE REQUIREMENTS

Public Act 06-195 Changes Professional Counselor Licensure Requirements

Effective October 1, 2006, Public Act 06-195 changes the education criteria required for individuals seeking a professional counselor's license. Under current law, an individual must have (1) completed sixty (60) hours of graduate school semester hours related to the discipline of professional counseling by the National Board of Certified Counselors ("NBCC") and must have earned either (A) a master's degree of at least forty-two (42) graduate semester hours or a master's degree and a sixth year degree or (B) a doctoral degree; (2) acquired three thousand hours of post-graduate degree supervised experience; and (3) passed an examination. The new law requires licensure candidates to have one of the following: (i) forty-two (42) graduate semester hours in a major deemed to be in the discipline of counseling by the NBCC; (ii) a master's degree with a major in social work, marriage and family therapy, counseling, psychology or a related mental health field and a sixth year degree deemed by NBCC to be in the discipline of counseling; or (iii) a doctoral degree deemed by NBCC to be in the discipline of counseling. The required hours of post-graduate degree supervised experience and the exam requirement remain unchanged.

Public Act 06-195 Establishes Licensure Requirements for Physical Therapy Assistants

On April 11, 2006, the Commissioner of the Department of Public Health ("DPH") published notice

of the implementation of a regulation requiring mandatory licensing for Physical Therapist Assistants ("PTAs"). A failure to comply with the new licensure requirements by November 1, 2006, may result in disciplinary action imposed by DPH.

In accordance with the new regulation, to qualify for PTA licensure an individual must graduate from a program accredited by the Commission on Accreditation in Physical Therapy and successfully complete the National Physical Therapist Assistant Exam. Those individuals who registered as a PTA with DPH by April 1, 2006; graduated from an accredited program prior to April 11, 2006; completed twenty years of employment as a PTA prior to October 1, 1989; or are licensed by another state or country, may qualify for licensure without examination. Annual renewal of the license during a PTA's birth month is required.

Public Act 06-195 Clarifies the Use of the Title "Doctor"

Effective June 7, 2006, Public Act 06-195 permits those individuals with a doctor of medicine or doctor of osteopathy degree, but not licensed to practice in a clinical setting, to use the initials "M.D.," or "D.O.," as long as such individuals do not intend to represent or induce the belief that they practice medicine in the state, are licensed to practice medicine within the state, or may diagnose or treat any injury, deformity, ailment, or disease of another person for compensation, gain, or reward. The new law is not intended to restrict those individuals licensed to engage in the practice of the healing arts (e.g., chiropractor, podiatry, optometry, dentistry, etc.) from using the title "doctor." Rather, the new law clarifies that only a licensed medical doctor (including osteopathic and homeopathic physicians), may use or imply the use of the title "physician," "surgeon," "medical doctor," "osteopath" or "doctor," or initials thereof without any further designation. Other individuals licensed to engage in the practice of any branch of the healing arts are permitted to use such titles as long as the proper designations are also used, in accordance with corresponding licensure statutes.

This legislative update highlights some of the significant changes made to health care laws during the 2006 Connecticut legislative session and is not meant to be a complete list of all legislation affecting the health care industry.



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For questions regarding health care legislation, please contact a member of the Robinson & Cole Health Law Group.

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