Medical Litigation Newsletter

September 2011 Issue

Hinshaw Expands Medical Litigation Practice to Florida and California

Hinshaw is pleased to announce that the firm has expanded its Medical Litigation practice into Florida and California. This expansion now provides Hinshaw clients the ability to have medical malpractice cases defended coast-to-coast. The *Medical Litigation Newsletter* will be enhanced by featured legal developments in these new jurisdictions. Hinshaw's Medical Litigation Group continues to thrive and expand under the leadership of Group Leader, Daniel P. Slayden.

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Reporting Payments to the National Practitioner Data Bank

Introduction

The Health Care Quality and Improvement Act of 1986 (HCQIA), 42 U.S.C. § 11101, *et seq.*, was established, in part, to improve the quality of medical care throughout the nation. In furtherance of this goal, the HCQIA mandates that various health care entities report certain payments made in resolution of medical negligence cases to the National Practitioner Data Bank (NPDB).

This article includes: (1) an assessment of the current guidance offered regarding when such "payments" trigger mandatory reporting to the NPDB; (2) a discussion of the various implementing regulations regarding NPDB-payment reporting, which are published in the Federal Register and codified at 45 C.F.R. Part 60; (3) highlights of relevant portions of the NPDB Guidebook (Guidebook), U.S. Dep't of Health and Human Services, Pub. No. HRSA 95-255,

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Hinshaw Representative Matters

Each issue of the Medical Litigation Newsletter highlights a few recent cases handled by Hinshaw lawyers.

We are pleased to report the following:

Jeffrey R. Glass and ***Madelyn J. Lamb***, Partners in the Belleville, Illinois, office of Hinshaw & Culbertson LLP, successfully obtained summary judgment on the eve of trial in favor of defendant physician in a medical malpractice case pending in the generally regarded pro-plaintiff St. Clair County, Illinois. The case involved an allegation that the physician had negligently failed to properly monitor the subject patient while on Cytoxan and Prednisone for the treatment of a serious kidney disease resulting in her death. The court agreed that the physician was entitled to summary judgment because plaintiff failed to offer any expert testimony that the patient's death was a proximate result of any action or failure to act on the physician's part.

Paul C. Estes and ***Jesse A. Placher***, attorneys in the Peoria, Illinois, office of Hinshaw & Culbertson LLP, obtained not guilty verdicts on behalf of a physician, a health care system and a trustee, in a medical malpractice case. Plaintiff, the administrator of a decedent's estate, brought the lawsuit following the death of the decedent, a three-year-old boy, who had been treated by defendants on seven different occasions in 2003 for complaints of cough, ear and upper respiratory infections. The decedent was ultimately found to have

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Chap. E-8 (Sept. 2001); and a general overview of the relevant statutory, regulatory and agency resources for those who are unfamiliar with this area of the law. The information contained herein should not be construed as legal advice, or substituted for the advice and guidance of attorneys with experience in filing reports with the NPDB.

Who Must Report?

Attorneys representing hospitals, doctors or other health care entities or professionals against claims raised in medical malpractice lawsuits are not necessarily responsible for filing a report with the NPDB when a payment is made in resolution of such a lawsuit. Rather, the entity making an actual payment on behalf of a health care professional in resolution of these cases must make a determination regarding whether mandatory reporting has been triggered. As set forth in the HCQIA:

Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 11134 of this title, information respecting the payment and circumstances thereof.

The implementing regulations further clarify that the entity that makes the payment is ultimately responsible for reporting it to the NPDB. Irrespective of which person or entity bears the ultimate burden of reporting to NPDB, defense counsel can benefit greatly from becoming familiar with the various statutory, regulatory and agency resources governing this issue. In the context of settlement, doctors, nurses or other health care practitioners will likely inquire into the issue of reporting obligations to the NPDB. Knowledge of this information allows defense counsel to offer invaluable guidance and insight to the practitioner as he or she attempts to arrive at a decision regarding settlement.

To Whom Must Information Be Reported?

When an event triggers reporting, information must be reported both to the Secretary of the Department of Health and Human Services (Secretary) and to the state licensing board(s). The appropriate state licensing board to which reporting must be made is that of the state in which the act or omission upon which the medical malpractice claim was based. The Guidebook provides a list of state medical and dental boards organized by state. Note, however, that names and street addresses are current as of the Guidebook's September 2001 publication date.

What Information Must Be Reported?

A health care practitioner may inquire what information would be reported to the NPDB in the event of a reportable settlement being made. Generally, information about the practitioner, the events underlying the payment, and the payment itself must be made. First, the following information regarding the practitioner on whose behalf payment is made must be reported to the NPDB: (1) his or her name; (2) the name (if known) of any

hospital with which he or she is affiliated or associated; (3) his or her work address; (4) his or her home address, if known; (5) his or her social security number, if known; (6) his or her date of birth; (7) the name of each professional school attended and year of graduation; (8) for each professional license: the license number, the field of licensure, and the name of the state or territory in which the license is held; and (9) his or her Drug Enforcement Administration registration number, if known.

Second, the following information regarding the payment, and the events underlying it, must be reported to the NPDB: (1) the amount of the payment; (2) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based; (3) where an action or claim has been filed with an adjudicative body, identification of the adjudicative body and the case number; (4) the date(s) on which the act(s) or omission(s) which gave rise to the action or claim occurred; (5) the date of judgment or settlement; (6) the date of payment, and whether payment was for a judgment or settlement; (7) a description and amount of judgment or settlement and any conditions attached thereto, including terms of payment; (8) a classification of the acts or omissions in accordance with a reporting code adopted by the Secretary. Note that the Secretary may occasionally revise, add to or subtract from the above-described lists of information required to be reported.

When Must Reporting Occur?

Mandatory reporting must occur within 30 days from the date that a payment is made, not within 30 days of settlement. The 30-day period commences on the day following the date of payment.

When Is Mandatory Reporting Triggered?

Unfortunately, neither the HCQIA nor its implementing regulations provide a complete explanation of when exactly a payment made in a medical malpractice case triggers mandatory reporting to the NPDB. Under the HCQIA, a "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any state or the United States seeking monetary damages. The implementing regulations clarify that these actions, if filed before other adjudicative bodies, also constitute medical malpractice action(s) or claim(s) falling within the HCQIA's ambit. Notably, the definitions provided under the HCQIA and its implementing regulations define neither "payment" nor "settlement." This leaves unanswered the question, "when must a payment made in resolution of medical malpractice action or claim be reported to the NPDB?" In some, but certainly not all, cases the Guidebook provides answers to this question.

But the guidance in the Guidebook is not necessarily binding upon all courts. Therefore, review of reported decisions to determine how much weight or authority that courts have accorded to the Guidebook in a given jurisdiction is advisable prior to relying on the guidance contained

Non-Hodgkin's Lymphoma after he had arrested. The administrator alleged that the coughing was continuous throughout the year and required a chest x-ray by the physician and a physician's assistant. The administrator also claimed that the standard of care required a chest x-ray when a steroid such as Pediapred is prescribed. After deliberating just two hours, the jury rendered its verdict for defendants.

Michael Henrick and ***Rich Kolodziej***, attorneys in the Chicago office of Hinshaw & Culbertson LLP, successfully tried a case to a defense verdict for defendant anesthesiologist/pain management physician in Lake County, Illinois. Plaintiff patient, a 64-year-old woman, was claiming brain damage as a result of a fall from a surgical table. The procedure for which the patient saw the physician had been completed, and the physician had turned to dictate her report when the fall occurred. The patient was under conscious sedation at the time and had no memory of the event. The patient proceeded on general malpractice theories as well as on *res ipsa loquitor*, meaning that she only needed to prove that the doctor had management and control of her prior to the fall, and that such falls do not normally occur in the absence of negligence. While the jury found in favor of the physician, a verdict in the amount of $800,000 was returned against the codefendant hospital.

therein. In Illinois, for example, at least one appellate court has stated that the Guidebook is entitled to substantial deference, as it bears the Department of Health and Human Services' interpretation of its own regulations. *Diaz v. Provena Hospitals*, 817 N.E.2d 206, 211 (2nd Dist. 2004). At least one federal district court has followed the Guidebook as well. *Simpkins v. Shalala*, 999 F. Supp. 106 (D.D.C. 1998).

The Guidebook provides two important limiting principles. First, reportable "payments" must be the result of a written complaint or claim demanding monetary payment for damages. In other words, payments made based solely upon oral demands are not reportable. Second, reportable medical malpractice "payments" are limited to exchanges of money. In addition to these two broad limiting principles, the Guidebook offers specific guidance regarding a broad range of hypothetical "payments," providing further clarification on when mandatory reporting is (or is not) triggered.

Individuals. Payments made as a result of a lawsuit or claim made solely against an entity (for example, a hospital, clinic or group practice) that does not name an individual practitioner is not reportable. Similarly, individual health care practitioners who make payments out of their own pocket for their own benefit need not report such payment. *Simpkins v. Shalala*, 999 F. Supp. 106 (D.D.C. 1998) (NPDB regulation requiring each "person or entity" that makes a medical malpractice payment is invalid, insofar as it required individuals to report such payments). But note that a professional corporation or other business entity comprised of a sole practitioner that makes a payment for the benefit of a named practitioner must report that payment to the NPDB, unless the payment is made out of the sole practitioner's personal, rather than corporate, funds.

Dismissals. If a health care practitioner is dismissed from the lawsuit prior to the settlement or judgment, a payment made to settle the medical malpractice claim or satisfy a judgment is not reportable. Individual practitioners must be named both in the written complaint or claim demanding monetary payment for damage and in the settlement release or final adjudication, if any, for the payment to become reportable. Therefore, if practitioners are named in the release, but not in the written demand or lawsuit, payments made are not reportable to the NPDB. If a practitioner named in the written complaint or demand is subsequently dismissed from the suit and not named in the release, then payments made are not reportable.

Note, however, that if the dismissal results from a condition in the settlement or release, then the payment is reportable. Further, if the practitioner is dismissed from the lawsuit in consideration of the payment being made in settlement of the lawsuit, or the practitioner agrees to a payment on condition that his or her name does not appear in the release, the payment can only be construed as a payment for the benefit of the practitioner and must be reported to the NPDB.

Refunds. While a refund of a practitioner's fee made by an entity is reportable to the NPDB, such refunds, if made by an individual, are not reportable. Similarly, a refund of a fee is reportable only if it results from a written complaint or claim demanding monetary payment for damages. A waiver of a debt is not considered a payment and should not be reported to the NPDB.

Loss Adjustment Expenses. Loss adjustment expenses (LAEs) refer to expenses other than those in compensation of injuries, such as attorneys' fees, billable hours, copying, expert witness fees, and deposition and transcript costs. LAEs not included in the medical malpractice payment amount need not be reported to the NPDB.

High-Low Agreements. A payment made at the low end of a high-low agreement is reportable only if the fact-finder (at trial or arbitration) rules in favor of the defendant and assigns no liability to the defendant-practitioner. Such a payment is not reportable because it is made pursuant to an independent contract between the defendant's insurer and the plaintiff. Where the verdict or decision is in favor of the plaintiff and a finding of liability is entered, a payment made at the high end of the high-low agreement is reportable.

Insurance Company Reimbursement. An insurance company that reimburses a practitioner for such a payment (makes a payment in response to the medical malpractice claim or judgment) must report that payment to the NPDB, as long as the patient submitted the demand in writing.

Confidential Settlement Agreement. Confidential terms of a settlement or judgment do not excuse an entity from the statutory requirement to report that payment to the NPDB. The reporting entity should explain in the narrative section of the Medical Malpractice Payment Report that the settlement or court order stipulates that the terms of the settlement are confidential.

What If Reporting Does Not Occur?

A malpractice payer that fails to report medical malpractice payments in accordance with 42 U.S.C. § 11131(c) is subject to a civil money penalty of up to $11,000 for each such payment involved. Although the statute requires only an insurer to report payments, a physician who knowingly or negligently violates the statute is subject to a monetary penalty.

Conclusion

While the statutory and regulatory language leaves unanswered many questions regarding whether medical malpractice payments trigger mandatory reporting, the Guidebook offers valuable guidance in many hypothetical payment scenarios. Depending upon the weight of authority the Guidebook carries in a given jurisdiction, the Guidebook may offer definitive guidance regarding whether payments trigger mandatory reporting. Nevertheless, the Guidebook provides an excellent, plain language resource for attorneys and nonattorneys alike to gain familiarity with the principles involved with NPDB reporting.

An attorney who represents a health care practitioner or entity in a case involving medical malpractice claims could benefit greatly by becoming famimliar with the above-discussed statutory, regulatory and agency resources governing reporting payments to the NPDB. Understanding the obligations, risks and benefits involved allows defense counsel to provide meaningful guidance to health care practitioners who may be considering the consequences or benefits of refusing or agreeing to make a payment in resolution of a medical malpractice claim.

Contact for more information: Jason K. Winslow

Court Evaluates Abortion Remorse Case Through Lens of Doctrine of Informed Consent

On December 8, 2004, plaintiff, a 19-year-old woman who was approximately 12-weeks pregnant, sought counseling and assistance from defendant health care provider. The expectant mother asked a counselor employed by the health care provider whether an abortion "would terminate the life of a human being in the biological sense." The counselor replied in the negative, and the expectant mother underwent an abortion that same day. Two years later the formerly expectant mother sued the health care provider for failing to inform her that an abortion procedure would "terminate the life of the second patient, a living human being as a matter of biological fact." The counts of the complaint included wrongful death, negligent infliction of emotional distress and a violation of the Consumer Fraud and Deception Business Practices Act. The court evaluated the formerly expectant mother's claims through the lens of the doctrine of informed consent and ruled that the health care provider owed the formerly expectant mother no legal duty to offer opinions reflecting something other than the "scientific, moral, or philosophical viewpoint of [the health care provider] as an abortion clinic."

Doe v. Planned Parenthood Chicago Area, 2011 IL App 091849 (1st Dist. Aug. 19, 2011)

Contact for further information: Thomas R. Mulroy

Illinois Supreme Court Holds Federal Arbitration Act Preempts Nursing Home Care Act

Plaintiff, the administrator of a decedent's estate, sued a nursing home alleging that it had negligently provided services to the decedent that resulted in injuries and contributed to her death. The trial court denied the nursing home's motion to compel arbitration pursuant to two signed arbitration agreements, and the appellate court affirmed, holding that the arbitration agreements were void for being against the public policy set forth in the anti-waiver provisions of the Nursing Home Care Act (NHCA). The Supreme Court of Illinois reversed, holding that the Federal Arbitration Act (FAA) preempted the NHCA. The case had been remanded for consideration of other issues including whether the parties' arbitration agreements concerned a transaction "involving interstate commerce" within the meaning of Section 2 of the FAA; whether the arbitration agreements were void for a lack of mutuality; and whether the arbitration agreements applied to the administrator's claim under the Wrongful Death Act.

The Court believed that the record established that the arbitration agreements concerned a transaction involving interstate commerce, noting that the nursing care was paid for by Medicare and that the nursing home had received various supplies and services from vendors located in several states.

In discussing the legal doctrine of mutuality, the Court believed that the arbitration agreements had to be supported by consideration or mutually binding agreements to arbitrate. The Court held that because the arbitration agreements did not apply to claims less than $200,000—essentially ensuring that none of the nursing home's claims against the patient would have to be arbitrated under the terms of the agreement—the nursing home's alleged mutuality of promise to arbitrate was illusory. The Court felt that the nursing home could not offer any realistic scenario where the amount in controversy and disputes relating to the nonpayment of the decedent's care would equal or exceed $200,000. The arbitration agreements therefore did not contain mutually binding promises to arbitrate, but only a unilateral obligation on the patient's part to arbitrate her personal injury claims, and so were not enforceable.

Finally, the Court noted that even if the arbitration agreements were valid, the administrator's signature on the May 20, 2005, agreement was not binding as to arbitration of a wrongful death claim. The decedent had signed one of the arbitration agreements herself and the administrator had signed the other agreement as the decedent's "legal representative," not in her individual capacity.

In concurring in part and dissenting in part, one of the justices stated that because both parties had agreed to arbitrate all claims when the amount in controversy was greater than $200,000, their promises were equal—such as, for example, had the resident accidentally or intentionally caused a fire.

Carter v. SSC Odin Operating Company, LLC d/b/a Odin Healthcare Center, 2011 WL 3652441 (5th Dist. 2011)

Contact for further information: Thomas R. Mulroy

Court Upholds Bar of Cross-Examination of Defense Expert About His "Personal Practices" in Medicine

In a medical maplractice case based on alleged doctor negligence, the jury found in favor of defendants, doctors and others, and against plaintiff patient. The trial court had granted a motion *in limine* to bar a defense expert from being cross-examined about his "personal practices" in medicine. The appellate court affirmed, holding that the expert's preference to use one of the three treatment options that he opined were all within the standard of care to treat the ailment did not give rise to permissible impeachment testimony. The expert's preference for one method was ruled to be not inconsistent with his testimony that all three appropriate treatment options existed. The patient relied on *Gallina v. Watson*, 354 Ill. App. 3d 515 (2005) and *Schmitz v. Binette*, 368 Ill. App. 3d 447 (2006). The court ruled that unlike in *Gallina*, this expert did not state that he always used the treatment option advanced by the patient or that he never used the treatment option used by defendants. Thus his credibility on this issue was not affected. The patient also complained that one of defendant doctors failed to correctly define the legal standard of care and thus that his testimony was unreliable. The court held that the doctor's failure to comply verbatim with the Illinois Pattern Jury Instruction in defining "standard of care" was irrelevant given that his testimony clearly demonstrated his opinions were based on his education, training and experience.

Taylor v. County of Cook, 2011 WL 3112852 (1st Dist. July 21, 2011)

Contact for further information: Thomas R. Mulroy

Hinshaw & Culbertson LLP prepares this newsletter to provide information on recent legal developments of interest to our readers. This publication is not intended to provide legal advice for a specific situation or to create an attorney-client relationship. We would be pleased to provide such legal assistance as you require on these and other subjects if you contact an editor of this publication or the firm.

The Medical Litigation Newsletter is published by Hinshaw & Culbertson LLP. Hinshaw & Culbertson LLP is a full-service national law firm providing coordinated legal services across the United States, as well as regionally and locally. Hinshaw lawyers represent businesses, governmental entities and individuals in complex litigation, regulatory and transactional matters. Founded in 1934, the firm has approximately 500 attorneys in 24 offices located in Arizona, California, Florida, Illinois, Indiana, Massachusetts, Minnesota, Missouri, New York, Oregon, Rhode Island and Wisconsin. For more information, please visit us at www.hinshawlaw.com.

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