

# MEDICAL MALPRACTICE UPDATE

March 2010

## NEW COMPLIANCE RULES STEMMING FROM THE MEDICARE, MEDICAID, SCHIP EXTENSION ACT DELAYED, BUT COMPLIANCE EFFORTS CONTINUE...

By: Adil A. Daudi, Attorney

For over a year now, the health care team at Smith Haughey Rice & Roegge has been busy assisting insurers and third-party administrators as they develop plans and procedures to comply with Section 111 of the Medicare, Medicaid, SCHIP Extension Act (MMSEA). On February 25, 2010 CMS posted new information on its Web site informing liability insurers, workers' compensation insurers and self-insured entities (defined as "NGHPs") that reporting of live claim input files is moved from the original deadline of April 1, 2010 to January 1, 2011. The immediate impact of this change is that entities subject to the reporting requirements now have additional time to register and test their processes for reporting claims to CMS. Additionally, CMS indicates that in February they will publish the next version of the "NGHP Section 111 User Guide" and alerts related to particular policy issues.

By way of background, Section 111 of the MMSEA amended the Medicare Secondary

Payer Statute to impose mandatory data reporting requirements on liability insurers, no-fault insurers and workers' compensation insurers. MMSEA Section 111 now places an affirmative obligation on insurers to: (a) determine if a claimant is entitled to Medicare; and (b) notify CMS of said entitlement and report specific information regarding the claim directly to CMS.

MMSEA builds off of a separate federal statute called the Medicare Secondary Payer (MSP) Statute. Under the MSP Statute, Medicare is designated as the secondary payer for Medicare beneficiaries who also have group health plan (GHP) coverage, as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation (non-group health plans or NGHPs). The purpose of the Section 111 mandatory reporting requirement is to notify CMS of instances when Medicare

### *New SHRR Contact Cards!*

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beneficiaries receive payments that relieve CMS of its obligation to cover medical costs.

Notwithstanding the recent delay in the reporting schedule, we have begun to see the first stages of action by some responsible reporting entities (RREs), which is the term used under Section 111 to identify those GHP and NGHPs that will be making reports. These entities are beginning to gather the information necessary to generate the necessary reports. Specifically, a NGHP RRE is now required to report to CMS:

1. any claim that is addressed or resolved, fully or partially, through a settlement, judgment, award or other payment;
2. on or after October 1, 2010;
3. with a Medicare beneficiary (broadly defined to include all persons age 65 years of age or older or certain people under 65 years of age with qualifying disabilities);
4. where medicals are claimed or paid;
5. regardless of whether there is a determination or admission of liability.

The registration period for NGHPs on the Coordination of Benefits Secure Web site (COBSW) began on May 1, 2009 and by now most RRE's are registered and ready to begin the Claim File Testing process. Significantly, in light of CMS' recent delay in the reporting schedule, the targeted claims subject to reporting are claims made on or after October 1, 2010. CMS has indicated that RREs may choose, from a process perspective, to report claims prior to October 1, 2010. However, pursuant to the new information, the only claims subject to reporting are those occurring after October 1, 2010.

Additionally, some lingering questions remain in the insurance industry about whether the Section 111 rules have now added a requirement that Medicare Set Aside (MSA) arrangements be implemented in liability settlements involving a Medicare beneficiary. From the start of the Section 111 "rule-making" process, CMS has made it clear that MMSEA Section 111 does not change or alter any legal obligation/requirements under the Medicare Secondary payer statute. Therefore, insurers are still responsible for protecting Medicare's interest and Medicare still needs to be considered for both past (conditional payments/liens) and future payments. Satisfying Medicare's interest for future injury-related care in liability settlements has a host of issues that do not exist in the workers' compensation context, where MSAs are regularly employed.

As a general principle, the standard relative to evaluating whether an MSA should be considered in a liability settlement is based on the concept of whether the parties have "properly considered Medicare's interest" in negotiating the liability settlement. Some factors to consider in this regard include: (1) whether the parties have addressed Medicare's past "conditional payments" (e.g. issuing third-party checks listing Medicare as payee) and (2) whether future injury related care is expected (if not, is there physician written certification of this fact). All this being said, in some cases, the sheer size of some liability settlements, for instance in catastrophic injury cases, may suggest that there will necessarily be some future costs of care that Medicare will likely be paying for. These instances should be evaluated on a case-by-case basis to determine whether a MSA Arrangement may be appropriate.

Importantly, on February 25, 2010, CMS also published an Alert outlining information for RREs regarding how to remain in compliance

with the reporting requirements. According to CMS, RREs seeking to test their compliance with the Section 111 requirements should consider three factors: (1) has the RRE completed the registration process; (2) has the RRE engaged in file data sharing testing; (3) has the RRE begun and continued to engage in ordinary live data exchanges. Moreover, on its most recent conference, CMS stressed, once again, that the goal of the program is to generate quality data and RREs demonstrating a good faith effort to report accurate information to CMS will not likely be subject to penalties.

CMS is continuing to hold policy and technical related conference calls to resolve some still outstanding issues in this area. Additionally, an interesting future concern relates to how CMS plans on using the information generated in reports to initiate recovery action against, for instance, insurers.

Smith Haughey Rice & Roegge will continue to monitor developments in this area and distribute updated information as it becomes available.

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## CASE LAW UPDATE

October 23, 2009 – January 5, 2010

Edited by: Lindsay Weber, Law Clerk

### Michigan Supreme Court

Compton v. Pass, October 23, 2009

The plaintiff alleged that the defendants failed to obtain her informed consent and this breach of the standard of care caused her to undergo a more extensive medical procedure and as a result of the procedure, she sustained an injury. The Court of Appeals ruled that the trial court should have granted the defendants' summary disposition motion. However, the Supreme Court concluded that the evidence was sufficient to permit a fact-finder to find the alleged breach of the standard of care. The court remanded the case to the Court of Appeals for consideration of the remaining issues because the Court of Appeals erred in analyzing the case under the "lost-opportunity" standard in MCL 600.2912a(2).

### Michigan Court of Appeals

Zwiers v. Growney, October 22, 2009

The plaintiff alleged that she sustained injuries due to the defendant's negligent placement of a morphine pump. She served her notice of intent (NOI) on the defendants on August 30, 2007, and filed her complaint and affidavit of merit (AOM) on February 27, 2008. However, per the mandate of MCL 600.2912b (1), the complaint could not be filed before February 28, 2008. The defendants moved for summary disposition, which was granted by the trial court. The Court of Appeals reviewed the Supreme Court's decision in *Bush*, which found that "plaintiff's filing suit one day early in no way defeated the purpose and goal of Section 2912b to promote settlement." Pursuant to *Bush*, invoking MCL 600.2301 depends on a two-part test: (1) whether a party's substantial right is implicated and (2)

whether a cure of the error or defect would further the interests of justice. The Court of Appeals held that both prongs were satisfied and reversed the trial court's order, holding that the plaintiff's error in filing her complaint and AOM one day before the 182-day notice period elapsed did not affect the defendants' substantial rights and did not defeat the legislative purpose behind enactment of the NOI statute.

Dalmia v. Palffy, December 1, 2009

The plaintiff suffered a stroke and was taken to the defendant-hospital. His wife claimed she requested the administration of a clot-buster, t-PA. The drug was not given, and the defendant-doctor could not recall discussing the drug with the plaintiff's family. The plaintiff was admitted and the next day complained of a severe headache. A subsequent CT scan revealed an acute infarct in the posterior cerebral artery as well as a hemorrhage. The plaintiff alleged the defendants negligently failed to administer appropriate medications, including t-PA. Plaintiff's expert, an emergency medicine physician, testified administration of t-PA was the standard of care, and relied on positive outcomes in the National Institute of Neurological Disorders and Stroke study to support his position. The trial court dismissed the case and The Court of Appeals affirmed, finding that the data in that study was neither scientifically reliable nor generally accepted within the relevant expert community.

Taylor v. Kent Radiology, PC, December 22, 2009

Plaintiff fell and injured his foot. His family doctor sent him to defendant-hospital for an x-ray. The radiologist saw "no evidence of fracture". Plaintiff continued to have foot pain for a few months and the family doctor suggested the Plaintiff see an orthopedic

surgeon. New x-rays were taken, which revealed a broken talus. Plaintiff alleged the radiologist breached the standard of care and that his breach proximately caused a worsening of the fracture. At trial, the jury found the evidence confirmed a progression of the fracture between the original x-ray and the time the fracture was diagnosed. It was undisputed that the progression of the fracture not only made plaintiff's first reconstructive surgery harder to perform, but also necessitated a second surgery. After the trial, defendants moved for a remittitur (a lowered judgment amount) or a new trial and the plaintiffs moved for additur (an increased judgment amount). Both motions were denied. The Court of Appeals affirmed the \$273,675.18 judgment for Plaintiff, and found that sufficient evidence had been presented with respect to a causal relationship between the breach and the surgeries.

Farley v. Carp, January 5, 2010

In this trio of fact-specific cases, the Court of Appeals addressed when, and under what circumstances, previously adjudicated cases could be reopened under the principles of retroactivity enunciated in *Mullins*. All three of these cases were attempts to reinstitute claims where the plaintiffs had previously chosen not to pursue appellate and or remand remedies. The Court of Appeals reversed the trial court rulings, and ordered summary disposition entered in favor of the defendants, in all three cases.

Soufane v. Wu, November 12, 2009

The pregnant plaintiff called defendant obstetrician Wu, and told him she had felt a spurt of fluid and some pain near her kidneys. Dr. Wu initially treated this as a urinary tract infection. Ultimately, she was admitted to defendant McPherson Hospital, and then transferred to the University of Michigan, where her child was born prematurely and with significant

disabilities. Plaintiff alleged that Wu was negligent in failing to hospitalize her at the first sign of premature rupture of membranes. The trial court granted a directed verdict as to both

defendants on the issue of proximate cause. The Court of Appeals reversed as to Dr. Wu, holding that plaintiff had established a question of fact on causation.

## SMITH HAUGHEY'S MEDICAL MALPRACTICE DEPARTMENT NEWS & SUCCESSES

**Carol Carlson** won voluntary dismissals in two recent cases following extensive discovery. One case involved allegations against a psychiatrist for prescribing antidepressants to an adolescent which carried FDA warnings of possible increased suicidality. The second case involved claims that a physician's assistant overprescribed the pain medication Dilaudid for a woman who presented to the emergency department with unrelenting migraine headaches. No indemnity payment was made in either case.

**Cheryl Chandler** received a no-cause verdict on behalf of her ED doctor client in Monroe County. The case was related to the treatment of a facial wound/alleged human bite.

**Stephanie Hoffer** has joined the Smith Haughey as an associate in the medical malpractice department.

**Rob Tubbs** recently gave a presentation to the Munson Family Practice Residency Program on entitled: "The Deposition: A Primer for the Physician Witness".

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