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DEFENSE PRACTICE UPDATE

FALL 2013

Medicare Exclusion

By Thomas A. Mobilia and Katie L. Kohn

Exclusion, often referred to as the "death penalty" in the health care industry, prevents an excluded individual or entity from providing care, treatment, or other services to patients that are paid for by a federal health care program. In its recent Updated Special Advisory Bulletin,[1] the Office of Inspector General (OIG) for the Centers of Medicare and Medicaid Services (CMS) has addressed issues and questions that have frequently been raised regarding excluded persons and entities since OIG's first bulletin on the subject issued in 1999.[2] This article shall first review criteria by which an individual or entity can be excluded from Medicare, and then discuss the Updated Special Advisory Bulletin's focus on the responsibilities of employers of medical personnel to identify and avoid the employment of an excluded person, and the consequences of employing such an individual.

EXCLUSION

Exclusion is a remedial punishment that prohibits an individual or entity from being reimbursed by or participating in federal health care programs. OIG has sole authority to exclude individuals or entities from Medicare, and can do so under a number of mandatory and discretionary circumstances pursuant to Social Security Act §§ 1128, 1128A, and 1128B.

An individual or entity will be excluded on a mandatory basis from federal health care programs if the individual or entity has been convicted of (i) an offense related to the provision of services under Medicare or any state health care program; (ii) neglect or abuse of patients; (iii) felony health care fraud; or (iv) felony manufacture, distribution, prescription, or dispensing of a controlled substance.[3]

In addition, OIG may permissively exclude an individual or entity if that individual or entity has been convicted of: (i) misdemeanor fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with providing medical care; (ii) an offense related to the obstruction of an investigation or audit related to a federal health care program; or (iii) a misdemeanor regarding unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG can also exclude individuals or entities if the individual's or entity's license has been suspended or revoked by any state licensing authority or if the individual or entity has been suspended or excluded from a federal or state program due to a lack of professional competence, professional performance, or financial integrity. Fraud, kickbacks, and submission of excessive charges or unnecessary services to a federal health program can also serve as grounds for permissive exclusion from Medicare.[4]

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1 Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, U.S. Dept. of Health & Human Services, Office of Inspector General, May 8, 2013.

2 Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, U.S. Dept. of Health & Human Services, Office of Inspector General, September, 1999.

3 Social Security Act § 1128(a).

4 Social Security Act § 1128(b).

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If an excluded individual owns 5% or more of an entity, OIG may also exclude that entity if the individual was convicted of (i) an offense related to the provision of services under Medicare or any state health care program; (ii) neglect or abuse of patients; (iii) felony health care fraud; or (iv) felony manufacture, distribution, prescription, or dispensing of a controlled substance.[5] However, absent those factors, an excluded individual may maintain his ownership in an entity.

CONSEQUENCES OF EXCLUSION

Exclusion requires that no payment by a federal health care program be made for any items or services furnished by an excluded person or at the medical direction or on the prescription of an excluded person. Excluded persons and entities cannot submit claims, provide treatment to a patient whose claims are submitted, or in any way be associated with claims submitted to a federal health care program for a period of time determined by the Secretary of Health and Human Services ("Secretary"). Exclusion does not merely prohibit payments or submission of claims for items or services related to direct patient care, but also prohibits payments for items and services related to indirect patient care and administrative and management services. For example, an excluded person may not prepare surgical trays or review treatment plans for a procedure or patient for which federal health care program funds will be paid. An excluded person is also not permitted to perform services related to health information technology and support, strategic planning, billing and accounting, staff training, or human resources for a provider that furnishes items or services payable by federal health care programs.

A provider may be subject to civil monetary penalties if the provider submits claims which include items or services rendered by an excluded person, even if the excluded person does not receive payment from the provider for his or her services...

PENALTIES

The length of time that an individual or entity will be excluded is set forth statutorily and varies depending on the basis for the exclusion. In general, the Secretary can increase or decrease the exclusion period depending on aggravating or mitigating circumstances.[6] If an excluded person or entity violates the provisions of exclusion, the excluded person or entity is subject to a Civil Monetary Penalty of $10,000 for each claimed item or service furnished during the exclusion period, an assessment of up to three times the amount claimed for each item of service, criminal prosecutions, or civil actions. Violation of exclusion is also grounds for denial by OIG of the individual's or entity's reinstatement from exclusion.

EMPLOYMENT OF EXCLUDED INDIVIDUALS AND ENTITIES

Employers of medical personnel may incur the penalties of exclusion if they employ or contract with individuals or entities that have been excluded. Employing or contracting with an individual or entity that the provider knows or should know has been excluded from federal health care programs, may subject the provider to civil monetary penalties of up to $10,000 for each item or service furnished by the excluded person or entity which was payable directly or indirectly by a federal health care program, an assessment of up to three times the amount claimed, and program exclusion. A provider may be subject to civil monetary penalties if the provider submits claims which include items or services rendered by an excluded person, even if the excluded person does not receive payment from the provider for his or her services, such as, a volunteer or a subcontractor.

The Updated Special Advisory Opinion also provides guidance regarding limited circumstances under which an excluded person may be employed by, or contracted with, a provider that receives payment from federal health care programs; specifically: (i) if the federal health care programs do not directly or indirectly pay for the items and services furnished by an excluded individual or entity; or (ii) the provider employs or contracts with an excluded person to furnish items and services solely to non-federal health care program beneficiaries. It also indicates that a provider needs to maintain a separate account from which to pay the excluded individual or entity.

IDENTIFYING EXCLUDED INDIVIDUALS AND ENTITIES

As noted above, employers are responsible for excluded persons and entities that they know or should have known are excluded. In order to assist providers in identifying excluded individuals and entities, OIG has published, and updates monthly, a "List of Excluded Individuals and Entities" (LEIE), which is accessible to all providers on the OIG's website.[7] The LEIE puts all excluded persons on notice of the individuals and entities that are currently excluded from federal health care programs. Individuals and entities are removed from the LEIE once reinstated. The OIG website also has a searchable database, allowing

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5 Social Security Act § 1128(a).

6 Social Security Act § 1128(c).

7 http://oig.hhs.gov/exclusions/exclusions_list.asp.

FMLA:
20 Years Old and Still Evolving

By Steven M. Berlin

As the US Department of Labor celebrated the 20th anniversary of the Family and Medical Leave Act ("FMLA"), it unleashed new regulations which were followed by amendments proposed by Congress and a U.S. Supreme Court decision. Employers have always found the law challenging to administer. Now they have to absorb these complex updates and must keep abreast of changes yet to come.

The FMLA provides workers with 12 weeks of unpaid leave after the birth or adoption of a child or to care for themselves or a family member with a serious illness. However, the law only applies to workplaces with at least 50 employees, and workers must have been at their job for at least a year and have worked at least 1,250 hours in the year prior to the leave.

The U.S. Department of Labor celebrated the FMLA's 20th anniversary on February 5, 2013. The next day, it issued a new final rule ("Final Rule") applicable to the 2009 expansions to "military caregiver" and "qualified exigency" leave, which are categories of leave added to FMLA by Congress in 2008. The Final Rule was effective March 8, 2013, and is sure to be a challenge to implement.

Initially, military caregiver leave provided the following family members: spouse, parent, son, daughter, or next of kin, of a current servicemember injured in the line of duty with a serious health condition, with up to 26 work weeks of unpaid job-protected leave to care for that servicemember.

Now, under the Final Rule, the military caregiver leave is also available for the family member of a servicemember whose injuries preexisted his or her active duty but were aggravated by service in the line of duty. Further, the term "servicemember" now includes a veteran who was not dishonorably discharged if the family member first takes FMLA military caregiver leave within the five-year period from such discharge. There are specific requirements for how to calculate that five-year period and for defining serious injury or illness for a covered veteran.

Prior to the Final Rule, "qualified exigency leave" allowed eligible employees whose spouse, son, daughter, or parent is a military member of the Armed Forces, National Guard or Reserves and on active duty (in a foreign country) or notified of an impending call to active duty to take five days leave for: (1) short notice deployment; (2) military events and related activities; (3) childcare and school activities; (4) financial and legal arrangements; (5) counseling; (6) rest and recuperation; (7) post-deployment activities; and (8) additional miscellaneous activities.

Now, the Final Rule extends the limit for qualified exigency leave to a maximum of 15 days. Also, such leave can be taken to care for the servicemember's parent who is not capable of self-care if the care is necessitated by the servicemember's absence due to active duty.

The Final Rule also made a few other minor changes and required use by all employers of a new updated FMLA poster by March 8, 2013. As lawmakers and advocates gathered to celebrate the FMLA and these new requirements, many also pressed for further action to expand the scope of benefits under the law. In April 2013, Sen. Richard Durbin, D-Ill., reintroduced the Family and Medical Leave Inclusion Act to amend the law to permit leave to care for the following additional "family" members with a serious health condition: same-sex spouse, domestic partner, parent-in-law, adult child without a disability, sibling, grandchild or grandparent. A companion bill was introduced in the House by Rep. Carolyn Maloney, D-N.Y. The proposed amendment asserts that the concept of family has evolved and expanded over the past twenty years and seeks to bring the FMLA in-line with those changes.

FMLA provides workers with 12 weeks of unpaid leave after the birth or adoption of a child or to care for themselves or a family member with a serious illness.

Passage of such a bill may not be realistic in the current Congress, but a recent Supreme Court decision effectively accomplishes some of its goals. The case, *United States v. Windsor*, did not involve the FMLA at all, but the June 26, 2013 decision struck down Section 3 of the federal Defense of Marriage Act (DOMA) enacted in 1996, and effectively expanded applicability of the FMLA to same-sex spouses.

The language of the FMLA statute and regulations does not evince intent to preclude workers in same-sex marriages from taking advantage of its provisions. The FMLA actually defines a "spouse" rather vaguely as "a husband or wife, as the case may be." Regulations implementing the FMLA further specify that "spouse" means "a husband or wife as defined or recognized under State law for purposes of marriage in the State where the employee resides, including common law marriage in States where it is recognized."

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FMLA: 20 Years Old and Still Evolving *Continued from page 3*

Thus, arguably, under its own definitions of "spouse," the FMLA should apply to same-sex spouses in states like New York (which recognizes same-sex marriages), or New Jersey (which recognizes civil unions) as intended to have all the same rights and privileges as marriage.

However, Section 3 of DOMA, (which was enacted before same-sex marriage was legal anywhere in the country) amended the Dictionary Act, which provides rules of construction for over 1,000 federal laws and all federal regulations. Section 3 of DOMA defined "marriage" and "spouse" for federal purposes as excluding same-sex spouses. This conflicts with, but was widely accepted to preempt, the language of the FMLA leaving it up to the States to define marriage, as DOMA specifies its definitions are to apply "in determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States." In fact, in 1998, a Department of Labor opinion newsletter explicitly advised that only the federal definition of "marriage" and "spouse" as established under DOMA may be recognized for FMLA leave purposes. As such, same-sex spouses have been considered unable to utilize the FMLA to take job protected leave to care for a husband or wife with a serious health condition.

The *Windsor* case involved a challenge to Section 3 of DOMA by New York resident Edith Windsor, who sought to claim the federal estate tax exemption for surviving spouses when she inherited the entire estate of her same-sex spouse. In an interesting twist, the Obama administration refused to defend the case and agreed with Ms. Windsor that the law violated the Constitution. The law was instead defended by the Bipartisan Legal Advisory Group, a standing body of the U.S. House of Representatives. The District Court ruled against the United States. The Second Circuit affirmed. On June 26, 2013, the U.S. Supreme Court issued a 5–4 decision declaring Section 3 of DOMA to be unconstitutional "as a deprivation of the liberty of the person protected by the Fifth Amendment."

By striking the provision of DOMA that precluded recognition of same-sex spouses as unconstitutional, the *Windsor* decision adds a new wrinkle to implementation of FMLA. Same-sex spouses are "spouses" under federal law if they are "spouses" under state law. In New York, because same-sex marriage is recognized, and in New Jersey, because same-sex marriage is recognized as a civil union and civil union partners are to be treated as spouses, all federal laws and regulations that refer to spouses refer to traditional and same-sex spouses; as far as the law is concerned they are all spouses or to be treated like spouses. In other words, in New York and New Jersey, a same-sex spouse or civil union partner is to be treated as a spouse for all purposes under FMLA.

In 1998, a Department of Labor opinion newsletter explicitly advised that "only the Federal definition of "marriage" and "spouse" as established under DOMA may be recognized for FMLA leave purposes."

The *Windsor* decision did not address Section 2 of DOMA, which permits states to not recognize same-sex marriages performed in other states. While New York and New Jersey (through the device of civil unions) do recognize those marriages, most states do not. Accordingly, employers in states which do not recognize same-sex marriages will not be required to extend FMLA benefits to employees in such marriages.

Also, because the FMLA regulations define "spouse" based on where the individual resides, it is conceivable that not all spouses in a same-sex marriage who are employed in New York or New Jersey would be entitled to the benefit of the *Windsor* case if they reside in a state that does not recognize their marriage. On the day of the decision however, President Obama directed the Attorney General and his cabinet "to review all relevant federal statutes to ensure this decision, including its implications for federal benefits and obligations, is implemented swiftly and smoothly." It would not be surprising if the FMLA or its regulations are amended in the future to address that issue.

It is important that New York and New Jersey employers, and employers in all states that permit or recognize same-sex marriages, now review their FMLA policies and procedures for administration of those policies to make sure they are appropriately administered in light of the Final Rule and the *Windsor* decision. Employers should stay-tuned; more changes impacting FMLA implementation may be coming.

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Defending Hospitals against Vicarious Liability Claims

By John L.A. Lyddane & Barbara D. Goldberg

It is familiar law that a hospital cannot be held vicariously liable for doctors who are not its employees, and that a hospital is not liable where a patient receives treatment from a private attending physician.[1] Likewise, the mere "affiliation" of a doctor with a hospital or other medical facility, not amounting to employment, is not a sufficient basis for imputing the doctor's negligent conduct to the hospital.[2]

A well-known exception to these general rules applies where a patient enters a hospital through its emergency room, seeking treatment from the hospital itself rather than any particular physician. This exception, known as the "*Mduba*" exception, was created over thirty years ago in *Mduba v. Benedictine Hospital*,[3] where the Appellate Division declared that "[p]atients entering the hospital through the emergency room, could properly assume that the treating doctors and staff were acting on behalf of the hospital. Such patients are not bound by secret limitations as are contained in a private contract between the hospital and the doctor. Defendant held itself out to the public offering and rendering hospital services."[4]

The classic *Mduba* setting has been summed up as follows: ". . .decedent entered the hospital through the emergency room, defendant's employees called a number of physicians to attend decedent, decedent had no prior physician-patient relationship with any of the physicians in defendant's emergency room . . . and neither decedent nor plaintiff requested or explicitly consented to treatment by any particular physician in the emergency room. In these circumstances, decedent 'could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital.'"[5]

Vicarious liability may also be imposed under a theory of "apparent" or "ostensible" agency if there is a basis for finding that a physician was "held out" to a patient by a hospital as acting on the hospital's behalf. In order for vicarious liability to attach under this theory, the plaintiff must have accepted the physician's services in reliance upon the perceived relationship between the hospital and the physician, and not the physician's skill.[6]

While vicarious liability under either a *Mduba* or an ostensible agency theory may be impossible to avoid in cases where a patient is admitted to a hospital on an emergent basis without a specific referral, there are recurring fact patterns where the courts have held that vicarious liability will not be imposed. An important and often dispositive consideration is whether the patient was referred to the hospital by his or her private attending physician.

Private Physician Referrals

Several recent cases have held that hospitals were entitled to summary judgment where a patient was referred to a hospital by a private attending physician. Most recently, in *Corletta v. Fischer*,[7] the Appellate Division held that a hospital was entitled to summary judgment where it demonstrated "that the plaintiff's decedent was referred to the Hospital by her private physician, and that the treatment of the plaintiff's decedent was performed at the Hospital by private attending physicians."

A similar result was reached in *Gardner v. Brookdale Hospital Medical Center*.[8] There, the plaintiff was the private patient of a HIP group, which referred her to the defendant hospital on three separate occasions for prenatal testing and instructed her to go to the hospital for her delivery. Upon her admission to the labor and delivery department, she was treated by an obstetrician on call from the HIP group who had privileges at the hospital. The plaintiff had never previously met the assigned obstetrician or been informed that she might treat her.

Nevertheless, the Supreme Court granted summary judgment in favor of the hospital and the Appellate Division affirmed, holding that "[t]he evidence that Gardner did not request a specific doctor when she arrived at the hospital and had never heard of or met [the assigned obstetrician] before was insufficient to raise a triable issue of fact."

The relevant considerations in *Gardner* were that the patient's private physicians instructed her to go to the hospital; the on-call HIP attending obstetrician was assigned to her care; and that obstetrician made all the treatment decisions. Since the patient was known to be

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1 *See, e.g., Hill v. St. Clare's Hospital*, 67 N.Y.2d 72 (1986).
2 *Id.; see also Ruane v. Niagara Falls Memorial Medical Center*, 60 N.Y.2d 908 (1983).
3 52 A.D.2d 450 (3rd Dept. 1976).
4 *Id.* at 453 (citations omitted).
5 *Citron v. Northern Dutchess Hospital*, 198 A.D.2d 618, 620 (3rd Dept. 1993).
6 *See Hill, supra*, 67 N.Y.2d at 79-81; *see also Sampson v. Contillo*, 55 A.D.3d 588 (2nd Dept. 2008); *Dragotta v. Southampton Hospital*, 39 A.D.3d 697 (2nd Dept. 2007); *Searle v. Cayuga Medical Center at Ithaca*, 28 A.D.3d 834 (3rd Dept. 2006).
7 __A.D.3d__, 2012 NY Slip Op 08682 (2nd Dept. 2012).
8 73 A.D.3d 1124 (2nd Dept. 2010).

a HIP patient, the hospital did not assign her to the service of a different on-call attending, as would more closely resemble a *Mduba*/ostensible agency setting.

In addition, the patient was not admitted as an emergency room patient, but rather as a maternity patient in the labor and delivery department. This, in addition to the fact that she had been treated by private attending physicians from the HIP group throughout her pregnancy, is a further factor distancing the *Gardner* fact pattern from the *Mduba*/ostensible agency cases.

Even if a patient is initially admitted through the emergency room, however, a hospital may potentially avoid vicarious liability if the admission was at the direction of the patient's private attending physician. In *Schultz v. Shreedhar*,[9] the Appellate Division held that the plaintiff had failed to raise a triable issue of fact as to whether, in arriving at the defendant hospital's emergency room *at the direction of his private physician*, he sought treatment from the hospital rather than from the defendant Dr. Shreedhar, "the private attending surgeon who had been called to the hospital by the plaintiff's private physician and performed an exploratory laparotomy several hours later."

Similarly, in *Thurman v. United Health Services Hospitals*,[10] the decedent presented to the emergency room, but his care was almost immediately assumed by his private attending gastroenterologist, who admitted him into the intensive care unit and directed the course of his subsequent treatment. Under these circumstances, the Appellate Division concluded that the hospital would not be held vicariously liable for the negligence of an on-call radiologist, even though the radiologist was not known to the patient or the private attending physician, and was not requested by either of them. The Appellate Division stated that ". . . since decedent obtained treatment – in the emergency room and while admitted – from his independent treating physician, during which [the radiologist's] alleged negligence occurred, the emergency room line of cases – in which patients seek and receive treatment from the hospital – is inapplicable." [11]

Vicarious exposure may also be limited if it can be demonstrated that the patient or the patient's proxy requested a particular physician based on a recommendation by someone who was not affiliated with the hospital.[12]

Even where a physician has an honorary title which might suggest that he or she is being "held out" by a hospital as its employee or agent, vicarious liability will not attach if it can be made clear that the patient was referred

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to the doctor by the patient's private attending physician or otherwise selected the doctor independently of any perceived hospital affiliation. In *Nagengast v. Samaritan Hospital*,[13] the plaintiff sought to hold a hospital vicariously liable for a physician to whom she had been referred for radiation therapy. The radiologist saw the plaintiff at his office at the hospital and she subsequently received treatment there under his direction. In reversing an order which denied the hospital's motion for summary judgment, the Appellate Division noted that it was undisputed that the plaintiff was specifically referred to the radiologist by her private attending urologist for radiation therapy, and that she independently retained him for such purposes.

Since the radiologist was not employed by the hospital and maintained privileges with other area hospitals as well, and the patient sought treatment from him based on a referral from her private attending physician, the radiologist's use of the title "associated attending physician" while at the hospital, and his use of the hospital's stationery, were not sufficient to support the imposition of vicarious liability.

CLARIFYING THE STATUS OF TREATING PHYSICIANS

In addition, there is case law supporting the use of language in informational and consent forms to clarify the status of physicians who have privileges at a hospital, which may potentially defeat the "holding out" element of ostensible agency. Specifically, in *King v. Mitchell*,[14] the Appellate Division noted that it would be "*preferable for hospitals to clarify in their informational and consent forms the status of physicians enjoying privileges at the hospitals*," although it stopped short of holding that a hospital was affirmatively obligated to disclaim a physician as an employee in order to avoid the creation of ostensible agency. This language suggests that it may be possible to limit vicarious exposure, prospectively, for physicians such

9 66 A.D.3d 666 (2nd Dept. 2009).
10 39 A.D.3d 934 (3rd Dept. 2007).
11 *Id.* at 937 (citations omitted).
12 *See O'Regan v. Lundie*, 299 A.D.2d 531 (2nd Dept. 2002); *Ventura v. Beth Israel Medical Center*, 297 A.D.2d 801 (2nd Dept. 2002); *Culhane v. Schorr*, 259 A.D.2d 511 (2nd Dept. 1999).
13 211 A.D.2d 878 (3rd Dept. 1995).
14 31 A.D.3d 958 (3rd Dept. 2006).

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as anesthesiologists, radiologists and pathologists who may be involved in a patient's care following admission, if the patient is advised in the informed consent form or other admission documents that such physicians are employed by an independent practice group, or that they have privileges to practice in the hospital.

The Appellate Division in *King* declined to impose vicarious liability for the alleged negligence of an anesthesiologist who was a partner in an independent group of anesthesiologists who had privileges at the defendant hospital. Once again, an important consideration was that the plaintiff sought treatment from an independent surgeon who admitted her to the hospital. "That plaintiff may have suffered injury at the hands of another physician practicing at [the hospital], does not automatically alter the relationship between plaintiff and [the hospital]; plaintiff did not enter the hospital based on a proffer by the hospital to the public to provide anesthesiology services but, rather, because her physician chose the hospital as the setting for her surgery."[15]

In other cases, however, the courts have found issues of fact as to hospitals' vicarious liability for employees of practice groups that were closely affiliated with the hospitals, and whose ability to practice elsewhere was limited by their agreements with the hospitals.

A leading case in this regard is *Dragotta v. Southampton Hospital*,[16] where the issue on appeal was whether the defendant hospital was vicariously liable for the actions of two anesthesiologists employed by an independent practice group who provided anesthesiology services to the plaintiff's decedent. The Appellate Division held that the plaintiff had raised an issue of fact as to apparent agency by offering proof that the hospital was contractually obligated to use anesthesiologists from the group, and that the anesthesiologists were prohibited from practicing elsewhere without the hospital's written approval. In addition, the contract directed the group to nominate one of its members as the hospital's Director of the Department of Anesthesiology, and all of the forms and questionnaires used by the anesthesiologists, including a "Patient Education" form which the decedent filled out and signed, bore the logo or letterhead of the hospital.

The Appellate Division held that the fact that the anesthesiologists were required to practice exclusively at the hospital absent written approval by the hospital, and that the hospital could only use the group's anesthesiologists, raised a triable issue of fact as to whether the hospital was holding itself out as a provider of anesthesiology services, notwithstanding the fact that the anesthesiologists were not employed by the hospital, which was never disclosed to any of the patients. The Appellate Division found it significant that "all of the forms and questionnaires used by the anesthesiologists bear the logo of the Hospital, including those filled out and signed by the decedent," and that the pre-anesthesia testing might have taken place at the hospital.

Dragotta thus confirms the potential importance of clarifying the status, prospectively, of physicians such as anesthesiologists and radiologists, who are not hospital employees, as members of an independent practice group.

CONCLUSION

In sum, while every case will be dependent on its own facts, the foregoing cases demonstrate that there are many situations where a hospital can successfully defend against a claim of vicarious liability for a non-employee physician, and that measures clarifying the status of treating physicians may even be taken prospectively in an attempt to limit vicarious exposure. While an aggressive disclaimer of employment status might appear contrary to the goal of instilling patient confidence, explaining through admission literature that physicians who may be involved in a patient's care are members of an independent practice group with privileges at the hospital should not have this effect. In addition, other unobtrusive methods such as patient education literature, brochures and signs may be implemented to clarify the status of treating physicians.

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15 *Id.* at 960 (citations omitted).

16 39 A.D.3d 697 (2nd Dept. 2007).

NEW STUDIES, THE STANDARD OF CARE AND MALPRACTICE CLAIMS

BY NANCY J. BLOCK

Malpractice occurs when treatment falls short of the standard of care. This begs the question — who then determines what is the standard of care? Physicians? Government? Insurance companies? If treatment or testing is not covered by insurance, does this mandate that such testing is not the standard of care? Should the corollary then follow – when treatment or testing is covered by insurance the minimum standard of care requirements are then met? Clearly, we can agree that insurance coverage does not set the standard of care at the present but what about in the future?

These questions or concepts may effect women's health care and, in turn, the malpractice industry. Late last year, the *New England Journal of Medicine* published a study which suggested that mammography contributed to an over-diagnosis of early stage cancers but had only marginally reduced the diagnosis of advanced cancer. The implication is that mammography as an early detection screening mechanism is not statistically successful. Not surprisingly, this notion is highly emotional and controversial – and, since the study was published, there has been much debate as to the appropriateness and efficacy of screening mammograms. Also, perhaps not surprisingly, plaintiff malpractice attorney websites cite to the study to share awareness on the harm in overly aggressive treatment for potential malignancy. Some of these websites suggest that as a result of the Affordable Care Act there is a look to evidence-based studies as establishing best practices in medicine. The question then becomes if evidence-based medicine and the consensus is against certain screening mammograms, will these tests no longer be covered by insurance, and thus are no longer deemed the standard of care? If this is the case, will a physician be able to rely on such studies as a shield against malpractice lawsuits? Although fairness may support such a rationale, reality does not. Claims of earlier detection are essential to virtually all failure to timely diagnose cancer cases. And, notably, these same websites do not suggest that screening mammograms are unnecessary. They only focus on the consideration that treatment may be too aggressive; i.e. unnecessary mastectomies, etc.

In March, the *New York Times* presented a new study led by researchers in Irvine, California on ovarian cancer. According to the study, women with ovarian cancer are drastically undertreated. This study too, was immediately picked up by plaintiff's malpractice attorneys who suggested a possible increase in malpractice claims due to the flaws in ovarian cancer treatment. According to the *Times*, the unpublished study analyzed medical records of over 13,000 women from 1999 to 2006 and determined that more than 80% of women were treated by low-volume providers (surgeons with 10 or less cases and hospitals will 20 or less) and were substantially undertreated. The study acknowledged that most ovarian cancers are diagnosed only in the advanced stage. As a result, it is critical to treat as per the guidelines set by the National Comprehensive Cancer Network with surgery and chemotherapy, depending on the stage. The study emphasized the importance of specialty care by facilities and gynecologic oncologists with familiarity and experience. Again, this sentiment was echoed by plaintiff's malpractice attorneys with the suggestion that it is the experienced physician, and only the experienced physician, who should treat patients with an ovarian cancer diagnosis. Thus, for a physician who is considered a low-volume provider, good practice suggests referral to a more specialized and experienced physician – and, from a medicolegal perspective, documentation of this referral is best.

What constitutes the standard of care has changed throughout history. Certainly, President James Garfield would have preferred if Listerian concepts had been embraced by his surgeons as the standard of care. For today, it remains to be seen what will have the greatest influences going forward. Regardless, it is always prudent to be cognizant of the changes in law and opinion that may sway the direction of medicine.

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THE OPMC
AND YOUR MEDICAL LICENSE

BY JOHN J. BARBERA

The Office of Professional Medical Conduct, ("OPMC"), is a branch of the New York State Department of Health. Most doctors have never heard of this agency. However, you should be aware of its existence and authority. The OPMC has the ability to review your medical records upon request, or investigate your medical practice, including the treatment of one or several of your patients. It can make findings that constitute professional misconduct,[1] bring disciplinary proceedings, and even revoke your medical license.

The primary mission of the OPMC, in the broadest sense, is to protect the public. It has the authority to regulate a physician's practice and has extensive investigational powers. The OPMC will shine a light on your practice under several different circumstances. Anyone can file a complaint. Usually, the complaint originates with an upset patient, or it may also emanate from a hospital or agency that has a duty to report certain physician conduct or changes in privileges. If you are a party to a settlement, or if a jury awarded damages against you in a medical malpractice case, the OPMC can initiate an investigation based on those outcomes. If you are disciplined in another state where you are licensed to practice medicine, or sentenced in New York State or another state to a criminal charge such as driving while under the influence, ("DUI"), the agencies involved in those incidents will eventually report the outcome to the OPMC which has the authority to take reciprocal action for out-of-state matters. (DUI is considered to be an act of professional misconduct.)

Often the OPMC will close an investigation following a record review with no further activity. However, it is common for the OPMC to seek an interview of the physician whom they are investigating – the so-called "target." If you are the target of an investigation, or even a possible target of an investigation, make no mistake, your legal interests are at stake. Often we see instances, after the fact, where a physician believes he can handle an OPMC request for records, or submit voluntarily to an interview in person or by telephone without the benefit of legal representation. Doing so is often a critical mistake. The OPMC has no duty to advise you whether you should obtain legal representation.

The interview process is often the most critical stage of the investigation. With thorough preparation, it is generally at that point in the investigation when a physician has the best opportunity to satisfactorily explain the circumstances under which she is being investigated. If a physician can successfully explain to the OPMC that her actions were reasonable, or that her treatment was appropriate, this will frequently result in a closure of the investigation, or conclude with a non-disciplinary resolution that remains confidential and non-reportable.

Representation by an attorney, who is familiar with the OPMC process, before, during and after the interview, will often mitigate the damage that can be done to your medical career. Once charges of professional misconduct are brought by the OPMC, the outcome tends to result in a disciplinary finding that becomes a matter of public record. The fall out from the OPMC investigation does not end there. The possible collateral effects of a disciplinary outcome can be serious. This includes the potential loss of privileges at hospitals that you are affiliated with, loss of credentials with health care maintenance organizations, an investigation by the Office of the Medicaid Inspector General that could result in exclusion from participation in the Medicaid and Medicare programs, and reciprocal disciplinary action in any other state where you maintain a license to practice medicine.

An OPMC investigation must be taken with the utmost seriousness. Knowledgeable counsel can often minimize the potential adverse outcome to your medical practice and career.

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1 New York State Education Law § 6530 lists the definitions of professional misconduct.

Medicare Exclusion *Continued from page 2*

employers to input names of individuals and entities to determine whether they are excluded.

The LEIE contains: (i) the name of the excluded person at the time of exclusion; (ii) the person's provider type; (iii) the statutory authority under which the person was excluded; (iv) the state where the excluded individual resided or the entity was doing business at the time of exclusion; and (v) a mechanism to verify search results via social security number or employee identification number.

No statutory requirements exist regarding when or how often providers should consult the LEIE. However, employers are presumed by OIG to have knowledge of the contents of the LEIE. Therefore, in order to limit liability under the Civil Monetary Penalties Law (CMPL),[8] OIG recommends that providers check the LEIE prior to employing or contracting with individuals and entities and then consult the LEIE's monthly updates to ensure that the individuals and entities employed have not been excluded subsequent to their employment. Employers should also include questions in employment applications requiring individuals and entities to confirm that they have not been excluded from federal or state health care programs.

CONCLUSION

Due to the significant consequences, including monetary penalties associated with exclusion and employing or contracting with excluded individuals or entities, it is important for individuals and providers to remain aware of all OIG policies and positions regarding exclusion and the employment of excluded individuals.

8 Social Security Act § 1128(a)

Thomas A. Mobilia is a Senior Partner and trial attorney at Martin Clearwater & Bell LLP. Mr. Mobilia has represented physicians and health care professionals in disciplinary proceedings brought by the New York State Department of Health, Office of Professional Medical Conduct, and by the Office of Professional Discipline. He has counseled and represented hospitals in physician staff credentialing proceedings. He is a frequent lecturer to risk management departments of major medical centers and serves as a legal advisor to one of the largest Independent Practice Associations in New York State.

Katie L. Kohn is an associate at Martin Clearwater & Bell LLP and focuses her practice on medical malpractice defense and healthcare law.

Recent Defense Verdicts

February 2013: Defense Verdict In Case Involving Claim of Improper Management of Perforation and Improper Surgical Technique

Partner Erik Kapner recently received a defense verdict in Supreme Court, Suffolk County following a 2 week trial. The case involved a 50 year-old woman who had developed diverticulitis of the colon and was admitted to the Hospital under the care of the defendant, a general surgeon. The plaintiff's diverticulitis was treated conservatively with bowel rest and antibiotics. She developed a perforation which caused an abscess and the defendant doctor performed an exploratory laparotomy but could not locate the source of perforation in the sigmoid colon. He therefore drained the abscess, inserted a drain tube and did not perform a colostomy. Post-operatively the patient developed a fistula which was managed conservatively. After discharge from the Hospital, the fistula broke down and she required readmission to the Hospital. A colostomy was performed by another surgeon and was later reversed at another hospital after 6 months.

Mr. Kapner asserted the defense claims that the defendant doctor used his best judgment and given his operative findings properly sought to avoid a colonstomy during exploratory laparotomy. The jury returned a unanimous verdict of no liability on behalf of the defendant doctor. Of interest is that following a major snowstorm, only 5 jurors remained and the parties stipulated to a verdict by 5 jurors, which had to be unanimous.

May 2013: Defense Verdict In Melanoma Case

Senior Partner Jeffrey A. Shor recently tried a case to a defense verdict. The case involved a 51 year-old married father of two, who presented to defendant dermatologist because of a suspicious mole on his back. The dermatologist promptly made a diagnosis of melanoma and referred the patient to the co-defendant oncological surgeon, who ordered a pre-operative PET/CT scan to ascertain that there was no metastasis of the cancer prior to his operative procedure wherein he performed a wide and deep excision of the lesion. The results of the radiology revealed a 5 millimeter subpleural nodule which was not believed to be of any significance but the radiologist who interpreted the scan indicated that a follow-up CT scan should be performed in the future. The patient only returned to the surgeon twice to have his sutures removed and did not follow the surgeon's advice to see him on a regular basis. Accordingly, the surgeon was not afforded the opportunity to order the follow-up CT scan. The dermatologist was aware of the outstanding CT scan and continued to see the patient approximately twelve times over the next two years for skin examinations. The dermatologist never ordered the follow-up CT scan as the interpretation of such a test was beyond his expertise. In December 2008, the patient was found to have wide spread metastatic disease in his lungs, liver, kidneys and brain, and died in March 2009. It was claimed that the dermatologist knew of the outstanding CT scan and should have ordered the same. The defense argued that a follow-up CT scan is an extremely sophisticated test requiring expertise well beyond that of a dermatologist and that the only obligation the dermatologist had to the patient was to advise him to return to see the surgeon.

However, the defense of this case was complicated by the fact that since the patient had died, The Dead Man's Statute was applicable and, hence, our client was not afforded the opportunity to testify as to any conversations that he had with the decedent. However, our client was able to testify as to those entries in his office records which indicated that the patient was exceedingly non-compliant. The plaintiff's attorney asked for $35,000,000 in damages and the jury returned a verdict after deliberating for 30 minutes in favor of our client.

May 2013: Defense Verdict in Case Involving Hole in Heart During Surgery

Partners Sean F.X. Dugan and Jacqueline D. Berger, assisted by associate Preethi Swamy, received a defense verdict in a case tried in Suffolk County. The case involved a 39 year-old woman who almost bled to death from a hole made in her heart while undergoing minor surgery. The plaintiff, a young, morbidly obese woman who required bariatric surgery was referred by her surgeon to the defendant vascular surgeon to place a filter into her inferior vena cava to help prevent blood clots from travelling up from her legs and lodging in her lungs as a result of the planned bariatric surgery.

The defendant introduced a guidewire into the jugular vein in plaintiff's neck, advanced it down her superior vena cava, and down into the right atrium of her heart. The tip of the wire strayed into the right ventricle of her heart. Unbeknownst to the defendant, it somehow perforated through the anterior wall of the right ventricle. The tip of the guidewire was than manipulated back into the right atrium, and down the right inferior vena cava. The heart bled 700 CC's of blood through the hole made in the heart, which than tamponaded in the pericardium. The patient went into shock. On opening the chest, and opening the pericardium, the blood sur-

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Recent Defense Verdicts *Continued from page 11*

rounding the patient's heart gushed out through the opened pericardium. The mechanism by which the hole through the heart occurred is unknown. The defense proved that the guidewire tip is soft, and curved. The defendant never rammed or jammed it as he advanced the guidewire through the blood vessels and never advanced the guidewire without observing same on the fluoroscopy screens.

Plaintiff's counsel was unable to prove the defendant failed to obtain his patient's informed consent, or that defendant carelessly advanced the guidewire, or that defendant advanced the guidewire without observing same on the fluoroscope screens.

June 2013: Jury Finds Diabetic's Death Unrelated To Deficient Medical Care

Senior Trial Partner John L.A. Lyddane recently tried a case to a defense verdict in the Supreme Court, Richmond County. The case involved a 48 year-old mother of two, who was a poorly controlled diabetic and died as a result of her first myocardial infarction, after 44 years of care by the defendant family practitioner. The Estate of the patient claimed that she should have had a workup of her cardiac condition which would have averted her death.

The defense focused on the absence of any proof that an earlier cardiology workup would have demonstrated a treatable lesion, and the doctor's effective management of a poorly compliant patient. Although the jury found that there should have been a cardiology referral, it also found that the failure to refer was not a cause of the patient's death.

June 2013: Jury Agrees Emergency Surgery For An Abdominal Perforation Was Timely Performed

Senior Trial Partner Jeff Lawton won a unanimous defense verdict in New York County involving the timing of a repair procedure for an abdominal perforation. Plaintiff's decedent was 66 years of age and previously had undergone a Whipple Procedure at a different institution. She presented to the Emergency Room and a flat plate X-ray revealed the presence of "free air". Plaintiff's expert claimed the Hospital was too slow in recognizing the perforation and should have done surgery an hour or two from the discovery of "free air". The defense countered that the plaintiff's decedent needed a CT scan to map out the corrective surgery, particularly, as the prior Whipple Procedure had altered the abdominal anatomy.

The defense experts explained the plaintiff needed fluid resuscitation in the Surgical Intensive Care Unit, otherwise the plaintiff would have expired on the surgical operating room table. Additionally, we were able to show that the plaintiff's decedent did not die due to the timing of the surgery, rather, she was severely immunocompromised as she was on chemotherapy.

MCB Welcomes Its Class of 2013

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