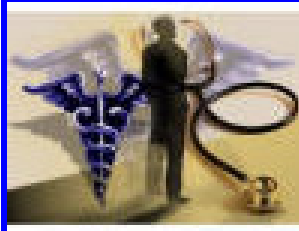


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## Health -E- News

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### SECTION NEWS

### DO NOT MISS

#### THE FALSE CLAIMS ACT AND THE HEALTHCARE INDUSTRY: NEW ISSUES FOR ATTORNEYS AND PROVIDERS

and

#### 2007 LEGISLATIVE UPDATE

Thursday, April 19, 2007

State Bar Center, Albuquerque

3.7 General CLE Credits (Both Sessions); 2.7 General (A.M.), 1.0 General  
(P.M.)

Standard Fee (Both Sessions)	\$129
Health Law Section Member (Both Sessions)	\$119

Standard Fee, (A.M. Session only)	\$95
Health Law Section Member (A.M. Session only)	\$85

Standard Fee, (P.M. Session only)	\$45
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Co-Sponsor: Health Law Section

**False claims issues addressed from 8:30 to 11:30 A.M.; lunch provided to registrants; and a legislative update from 12:30 to 1:30 P.M.**

### NEW DEVELOPMENTS IN HEALTHCARE LAW

#### Most Medical Malpractice Claims Tracked in Seven States Closed without any Payout – and a New Mexico Perspective on Malpractice Claims

The Department of Justice's Bureau of Justice statistics has issued a report that focuses on medical malpractice claims that were closed in Florida, Illinois, Maine, Massachusetts, Missouri, Nevada, and Texas from 2000 to 2004. In these states medical malpractice insurance providers are required by law to submit information on closed medical malpractice claims. These claims are typically submitted to the Department of Financial and Insurance Regulation, which provided the data to BJS. The report provides an in-depth analysis of medical malpractice claims, including the number of

claims closed with or without payouts, types of medical providers named in claims, facilities where alleged injury occurred, severity of alleged injury, court disposition of claims, amounts paid to compensate claimants, costs of defense counsel, and claim processing time.

Highlights include the following:

- Insurance companies in Florida, Illinois, Maine, Massachusetts, Missouri, Nevada, and Texas reported information on about 43,000 closed medical malpractice insurance claims between 2000 and 2004.
- Most medical malpractice claims were closed without any compensation provided to those claiming a medical injury. About a third of claims closed in Maine, Missouri and Nevada resulted in a payout. Among persons receiving compensation, insurance payouts were highest for claimants who suffered lifelong major or grave permanent injuries. In Florida and Missouri claimants with these types of injuries received median payouts ranging from \$278,000 to \$350,000.

For more information go to <http://www.ojp.usdoj.gov/bjs/abstract/mmicss04.htm>

**[Editor's Comment:** The New Mexico experience is remarkably similar. Since its inception in March 1967, the vast majority of claims brought before the New Mexico Medical Review Commission (NMMRC) were closed without a payment being made. A Commission panel conducts a hearing that may involve claims against one or more providers, and the panel issues a finding of "no negligence" or "negligence."

Statistics through February 28, 2007 show that since its inception forty years ago the NMMRC has handled 5458 claims against providers of all classes (MDs, DOs, CRNAs, DCs, DPMs, PAs, hospitals, and others). The frequency of claims (number of claims/cases filed) has steadily declined each year. "No negligence" was found in 69% of the cases. In 2006, 162 providers were brought before the NMMRC, and in 85% of the cases there was a finding of "no negligence." The fact that negligence was found does not mean that as a matter of reasonable medical probability an injury resulted from the negligence. In 1250 cases in which the NMMRC found negligence, it concluded that only 821 (66%) involved an injury.

Those who may have a jaded view of the work performed by the NMMRC should look at the litigation results. From its inception through February 2007, 1260 lawsuits has been filed, of which 913 were dismissed, 123 received summary judgment, 184 resulted in defense verdicts and 40 resulted in verdicts for the plaintiff.

In 1081 cases taken to court in which the NMMRC found "no negligence," 792 were dismissed, 100 were granted summary judgment, 153 resulted in defense verdicts and the plaintiffs prevailed in 26 of them. Of those cases not tried, 20.15% were settled, and 45.17% were dropped. The remaining 34.14% were tried.

In those 845 cases in which the panel found negligence to have occurred, 70.89% were settled, 7.57% were not pursued, and 21.18% were tried. Of the 179 cases tried, 121 were dismissed, 13 received summary judgment, 31 resulted in defense verdicts and the plaintiffs prevailed in 14 of them. (For the math savvy reader, the total of "no negligence" and "negligence" cases exceed 12601.) Multiple providers are often sued in the same lawsuit.

This being said, there are factors that may skew the statistics. For instance, in its annual report the NMMRC stated that "the statistics of patients prevailing at the NMMRC would increase if they excluded claims involving breast implants, steroid injections, Rezulin, and Fen-Phen cases that involved hundreds of patients who did not prevail at the commission." These patients prevailed; however, it was in class actions brought against the manufacturers, and not against individual providers. The extent to which they would have prevailed in a claim against the provider remains uncertain.

Over 550 professionals volunteer their time to serve on the NMMRC, and they provide a valuable ser-

vice to both patients and providers alike. Medical malpractice claims are among the most complex types of litigation. They can result in financial, emotional, physical (and judicial) stress on all concerned. Like it or not, the NMMRC has provided the citizens of New Mexico with a valuable service for the last forty years.

The Editor thanks G. Randy Marshall, Executive Director of the NM Medical Society, and Joseph Grant, Regional Claims Manager for American Physicians Assurance Corporation for their assistance in preparing this Comment.]

### **New Mexico governor authorizes medical marijuana.**

The [AP](#) (4/3) reports, "Nearly three decades after medical marijuana first was approved in New Mexico, Gov. Bill Richardson on Monday signed a law authorizing the state Department of Health to give the drug to some seriously ill patients." New Mexico is now the "12th state to legalize the use of marijuana for medical reasons," and Richardson noted that "the new law provides 'a humane option for New Mexicans living with cancer, HIV, and other serious medical conditions.'"

[Editor's Comments: For a discussion of this new law, come to the Legislative Update April 17, 2007.]

### **New Mexico bars drug prosecution of overdose patients.**

The [New York Times](#) (4/5, Blumenthal) reports, "Struggling with an epidemic of drug fatalities, New Mexico has enacted a groundbreaking law providing immunity from prosecution for people who come forward to help drug users suffering overdoses." The legislation, signed Monday by Governor Bill Richardson (D), was "popularly known as the 911 Good Samaritan Bill" and is "the first of its kind in the nation, according to the National Conference of State Legislatures." In addition to preventing prosecution of individuals who seek medical assistance for overdosing drug users, the measure also "protects drug users themselves from prosecution if the process of seeking help for an overdose provides the only evidence against them." The bill was "introduced by State Senator Richard C. Martinez, a Democrat and a retired magistrate judge from Espanola," and was supported by the Drug Policy Alliance, which works to ease drug penalties.

[Editor's Comments: For a discussion of this new law, come to the Legislative Update April 17, 2007]

### **Patient detained because of public health concern.**

The [New York Times](#) /AP (4/3) reports that Arizona's Maricopa County "health authorities obtained a court order to" lock up a 27-year-old patient who "suffers from an extensively drug-resistant strain of tuberculosis, or XDR-TB," which "is considered virtually untreatable." Officials suggest the man is a "danger to the public because he failed to take precautions to avoid infecting others. Specifically, he said he did not heed doctors' instructions to wear a mask in public." While the situation is rare, "health experts say it is a situation that U.S. public health officials may have to confront more and more because of the spread of drug-resistant TB and the emergence of diseases such as SARS and Avian flu in this increasingly interconnected world." The AP continues, "How to deal with people infected with the new strain is a matter of debate." Dr. Ross Upshur, Director of the Joint Centre for Bioethics at the University of Toronto, "said authorities should detain people with drug-resistant tuberculosis if they are uncooperative." University of Pennsylvania medical ethicist Art Caplan noted that "Maricopa County health officials were confronted with the same ethical dilemma that communities wrestled with generations ago when dealing with leprosy and smallpox. 'Drug-resistant TB, or drug-resistant staph infections, or pandemic flu will raise these questions again.'" He added, "We may find ourselves dipping into our history to answer them."

## **American College of Physicians releases mammogram guidelines.**

The [Washington Post](#) (4/3, A1, Stein) reports, "Reopening a long-running debate, the American College of Physicians, which represents 120,000 internists, issued new guidelines today that...urge women in their 40s to consult with their doctors about whether to have the breast X-rays." The guidelines, which "come less than a week after the American Cancer Society issued guidelines that, for the first time, recommend that women...undergo annual MRI exams," are based "on a comprehensive review of mammography research that concluded that the benefits are less clear for women in their 40s than for those 50 and older, and that screening carries significant risks, including exposure to radiation and unnecessary biopsies, surgery and chemotherapy." The ACP "asked a six-member panel of experts to develop new guidelines based on a review of scientific literature between 1966 and 2005" and concluded that the "possible 'modest' benefit for women in their 40s needs to be weighed against the risks." However, some experts condemned the guidelines, "saying mammograms help catch tumors at their earliest, most treatable stage, reducing the death toll from the common malignancy." Others maintain "the recommendations represent a more nuanced approach that better reflects what is known about the benefits and drawbacks of mammography."

## **CMS Clarifies Guidelines for NPI Deadline Implementation**

The Centers for Medicare & Medicaid Services (CMS) announced on April 2, 2007, that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007 deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final rule establishing the NPI as the standard unique health provider identifier for healthcare providers was published in 2004 and requires all covered entities to be in compliance with its provisions by May 23, 2007, except for small health plans, which must be in compliance by May 23, 2008. CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage healthcare providers who have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy, and free. Visit the [National Plan/Provider Enumeration System](#) (NPPES) website.

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions. CMS plans to make data available from the NPPES system that will assist covered entities in developing these "crosswalks."

To view this guidance, go to [http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI\\_Contingency.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf). To access the press release on this topic, [click here](#). More information and education on the NPI can be found at the [CMS NPI page](#) on the CMS website.

## **OIG issues Advisory Opinion regarding the use of credit card perks to reward employees.**

Want to pay your bills with credit cards and then use the perks to reward your employees? OIG says the scheme proposed by a nursing home is acceptable, and falls within the safe harbor for bona fide employer-employee relationships.

For a complete copy go to: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-03.pdf>

For a complete index of the OIG opinions go to <http://oig.hhs.gov/fraud/advisoryopinions/opinions.html>

## **Hospitals band together to standardize color-coded wristbands.**

In her [Wall Street Journal](#) (4/4) column, Laura Landro writes, "Hospitals are banding together to reduce the risk of deadly errors from...colored wristbands used to alert staffers to critical information about the most vulnerable patients." To fix the problem, "hospitals around the country have formed groups to standardize color designations in their states and regions, ...limiting the number of colors and bands to avoid confusion." Also, some hospitals are "purchasing bands embossed with pre-printed messages...and asking both patients and staffers to remove any colored charity or social-cause bracelets." Eventually, radio-frequency identification technology could "enable hospitals to use wristbands embedded with special chips both to track patient[s]...and access important information about allergies, medications and special orders." However, Landro notes, "the majority of hospitals...still rely on more archaic paper systems. For them, color-coded wristbands can provide an extra safety net." Many hospitals "are modeling their wristband initiatives on guidelines developed...in northeastern Pennsylvania, where hospitals started a grass-roots 'Color of Safety' task force" to standardize color definitions and educate hospitals and consumers.

### **California counties seek \$2.45 billion in Medicare payments.**

California's [North County Times](#) (4/5, Conaughton) reports that "San Diego and four other counties filed a claim Tuesday charging that the federal Medicare system had illegally withheld billions of dollars from doctors and counties nationwide." The claim is seeking "an estimated \$2.45 billion in back payments through 2001" along with changes to the Medicare system's "antiquated reimbursement system that characterizes San Diego County -- and more than 200 others nationwide -- as rural areas" and pays them 13-24 percent less than doctors in urban locales. Joining San Diego in the suit were the counties of Santa Cruz, Santa Barbara, Marin, and Sonoma. "Medicare officials declined to comment Wednesday, saying they viewed the claim as litigation."

[Editor's Comments: This is an interesting approach to "enhance" state health care funding. Note that it is a claim against Medicare – not Medicaid. It will be interesting to watch the development of this "claim."]

### **Federal judge rules HIPAA does not block police from obtaining information.**

The [AP](#) (4/4) reported, "A federal health privacy law does not keep police from getting information about a crime from a patient, 'nor does it prohibit hospital personnel from allowing police officers access to a patient who was a victim of a crime,'" U.S. District Judge Tucker Melancon ruled. Melancon threw out the lawsuit of Elizabeth Maier, who accused police of falsely arresting her for obstruction of justice. Melancon said that "the Federal Health Insurance Portability and Accountability Act does not block officers from getting information about a crime," noting "that the officers had obtained a warrant for Maier's arrest, meaning a judge had found probable cause for the charge. He said that provides protection against accusations of false arrest." HIPAA "generally bars hospitals from reporting instances of domestic abuse against mentally competent adults unless the victim agrees to the report." However, Lafayette police "accused Maier of improperly keeping Officer Todd Borel and his supervisor from seeing" the patient.

[Editor's Comments: HIPAA compliance becomes problematic when the police come knocking at the records center door. One's immediate reaction is to cooperate, but in some cases that is not the proper response. Recently, a rural clinic received a very broad subpoena from the New Mexico Office of the Medical Examiner. The clinic's former patient had committed suicide. We learned that under HIPAA, a provider may disclose patient information to the medical examiner for the purpose of identifying a deceased person, for determining cause of death, or for other medical examiner duties authorized by law. See 45 C.F.R. §165.512(g). The American Health Lawyers Association (AHLA) has produced a monograph in its Topical Insight Series: *Disclosure of Protected Health Information to Law Enforcement Under the HIPAA Privacy Standards* by Kristen Rosati, which is an excellent resource. It is written in Q&A format, and Ms. Rosati is one of the real Gurus of HIPAA].

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