



# RADIOLOGY LIABILITY ALERT®

*A bi-monthly nationwide review of medical liability for  
RADIOLOGISTS ■ PATHOLOGISTS ■ ONCOLOGISTS  
with medical liability analysis and risk management advisory  
by Ira J. Zarin, Esq.*

## Radiology Malpractice Review with Analysis

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# Malpractice Review

## Malpractice Verdict Review with Analysis

**\$2,978,000 VERDICT - RADIOLOGY - HOSPITAL NEGLIGENCE - FAILURE TO TIMELY INTERPRET SMALL BOWEL STUDY - BOWEL LEAK FOLLOWING SURGERY - CHEMICAL AND BACTERIAL PERITONITIS - ABDOMINAL HERNIA - DISFIGURING SCARRING.**

### CASE SUMMARY

The female plaintiff, a 65-year-old woman, underwent surgery to remove an ovarian cyst in January 2000. During the surgery, the plaintiff suffered a bowel leak. There was a ten day delay in diagnosing the bowel leak despite repeated diagnostic imaging studies that were taken at the defendant hospital and interpreted by its radiologists. The evidence demonstrated that one radiologist failed to timely interpret a small bowel study which resulted in a two day delay in taking the plaintiff back to surgery in order to repair the leak. In the interim, the plaintiff was required to ingest barium for the small bowel X-rays. The bowel was leaking into her abdomen, causing her to suffer chemical peritonitis along with the underlying bacterial peritonitis. The plaintiff had to undergo several surgeries to repair the injuries and two skin graft procedures. She was left with a very large abdominal hernia and permanent disfiguring scarring as a result of the incident.

### CASE DETAILS

The plaintiff brought suit against the defendant hospital and radiologists, alleging negligence in failing to timely diagnose and treat the bowel leak. The defendants denied the allegations of negligence and disputed liability.

After a seven day trial, the jury deliberated for five hours and returned its

unanimous decision in favor of the plaintiff and against the defendant. The jury awarded the plaintiff the sum of \$2,978,000, consisting of \$1,250,000 for past non-economic damages, \$1,500,000 for future non-economic damages and \$228,000 for medical expenses.

### RISK MANAGEMENT ADVISORY

***In this case, the plaintiff's entire cause of action was against the defendant radiology group for their alleged negligence in failing to timely diagnose and treat the bowel leak. It is interesting to note that there was no liability assessed by the judge and jury against the surgeons for their participation in this whole event, particularly the surgical intervention where the bowel leak was, in fact, created. Apparently there was no provable allegation of deviation on behalf of the surgeons involved for creation of the bowel leak, primarily because there was no particular evidence indicating a deviation in bringing about the bowel leak, which was deemed to have occurred by the very nature of the procedure itself and not by any provable deviation from acceptable standards of practice on behalf of the surgeons at whose hands the bowel leak originally occurred.***

***Practitioners are again reminded by this aspect of the case that where an untoward event occurs by the very nature***

***of a surgical procedure itself and not through any particular provable deviation in the performance of the procedure that brought about that offending poor result, the practitioners involved in that poor result will not normally be assessed liability unless it can be proven that they were responsible for a deviation in bringing about the poor result. It is the provable deviation in the course of the performance of any procedure that brings about liability to the surgeon or physician involved and not simply the fact that an adverse event occurred through the very nature of the procedure itself, as it was apparently deemed to be involving the surgeons in this particular case. However, liability was sustained against the radiology group for their failure to timely interpret the small bowel study and their other negligence in failing to timely diagnose and treat the bowel leak.***

***Practitioners should be aware of another important phase of liability that may well have existed in this case, even against the surgeons initially involved in the bringing about the bowel leak in the absence of any particular deviation. In this regard, practitioners are reminded that where an adverse event occurs with sufficiency frequency during a particular procedure to be considered a risk of that procedure***



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Although this publication serves to alert Health Care Professionals to litigation affecting their practice, because of variations in fact patterns and local jurisdictions, specific legal consultation should be obtained before acting on any information contained herein.

*...dure or surgical intervention, then there may conceivably be a deviation on behalf of the surgeons or physicians involved in failing to obtain an informed consent indicating the possibility of the occurrence of this complication even where it can and does occur in the absence of negligence, which may well have been the situation in this case.*

*In this regard, practitioners are reminded that when they perform a particular procedure that carries with it a known risk which can and does occur in the absence of deviation in the performance of the procedure by the very nature of the procedure itself, they can conceivably incur liability on the basis of a failure of informed risk where they fail to advise*

*the patient prior to the procedure of the possibility of the occurrence of this risk so that they can make a reasonable judgment as to whether or not to proceed with the surgical intervention.*

*Practitioners are further reminded that where there is a finding of a failure of informed consent, they can be held responsible for all the poor results of the procedure, which might otherwise not have been undertaken had there been a valid and appropriate informed consent advising of the risks of the particular occurrence. The recoverable poor results can also include the costs of any corrective*

*treatment, financial damages, and any permanent injury to the patient that may have occurred.*

#### **EXPERTS**

Plaintiff's general surgery expert: Leonard Milewski, M.D. from Rosemont, PA. Plaintiff's radiology expert: Seth Glick, M.D. from Philadelphia, PA. Defendant's infectious disease expert: Michael McIllroy from Detroit, MI. Defendant's radiology expert: Barry Bates, M.D. from OH.

#### **REFERENCE**

Shiawassee County, MI. Apsey vs. Memorial Hospital. Case no. 01-007289-NH; Judge Gerald D. Lostracco. Attorney for plaintiff: Frank Malfrice of Malfrice & Associates in Southfield, MI.

## **\$1,900,000 CONFIDENTIAL RECOVERY - PATHOLOGY NEGLIGENCE - FAILURE TO TIMELY DIAGNOSE MELANOMA UNDER FINGERNAIL - TWENTY-MONTH DELAY IN DIAGNOSIS AND TREATMENT - RECURRENCE THREE YEARS LATER RESULTS IN DEATH.**

### **CASE SUMMARY**

The male decedent first reported a change in his left thumbnail to his primary care physician in May 2000. On May 30, 2000, the decedent saw a dermatologist referred by the primary care physician. The dermatologist noted dystrophic left thumbnail and a defect of the nail bed. There was no noted evidence of an underlying neoplastic lesion.

### **CASE DETAILS**

In February 2002, the plaintiff's decedent again saw the primary care doctor with complaints regarding his left thumbnail. This time the decedent complained of a split left thumbnail. The doctor referred the decedent to a surgeon. The surgeon raised the possibility of a pyogenic granuloma, as opposed to a melanoma, in both his office notes and his operative notes. On February 26, 2002, the surgeon removed the left thumbnail and subungual lesion. Pathology records from the defendant indicated granuloma pyogenicum, a common benign vascular lesion.

On January 24, 2003, the plaintiff's decedent again saw his primary care physician with complaints regarding the same thumb. An infection was suspected and the doctor prescribed antibiotics. Nail clippings were negative for fungal organisms. Approximately seven months later, the decedent again presented with similar complaints. Another infection was suspected except this time clippings were positive for a yeast infection. The plaintiff's decedent was referred to a dermatologist once again.

The dermatologist noted during the August 29, 2003 visit that the left thumb plate was draining and lifted off. The dermatologist noted a large subungual tumor. It was planned to remove the nail plate and do a biopsy, but again it was suspected to be benign. The surgery was conducted on September 15, 2003. The pathology, at that time, was positive for malignant melanoma invasive to the reticular dermis. The plaintiff's expert obtained the prior pathology slides and it was determined that melanoma was present in 2002.

The decedent underwent an amputation of his left thumb and sentinel node biopsy from the left axilla on October 30, 2003. No residual melanoma was noted and the sentinel node biopsies were negative. The decedent suffered a recurrence and died as a result on February 4, 2007.

The plaintiff brought suit on behalf of the estate, the surviving wife and three adult children. The plaintiff alleged that the defendant pathologist was negligent in failing to diagnose the melanoma at the time of the 2002 surgery, which resulted in the decedent's ultimate death.

The matter was resolved in a confidential fashion for the sum of \$1,900,000 prior to the trial.

### **MEDICAL LIABILITY ANALYSIS**

The plaintiff's claim was based upon the extensive complaints and treatment sought by the plaintiff in connection with the decedent's injury. The plaintiff was able to demonstrate a chronological history of the repeated complaints regarding the nail, which were discounted by the various treating physicians as being

benign in nature and inconsequential in effect due solely and exclusively to the pathology report. The pathology report in 2002 indicated the granuloma pyogeuicum, which is a commonly recognized and benign vascular lesion.

When the decedent was finally correctly diagnosed in 2003 and prior slides from which the defendant pathologist were obtained and read, it became clear that the pathologist was erroneous. The 2002 slides reviewed in 2003 elicited an opinion that the melanoma was evident at that time and involved the margins. The decedent was told that he was at a great risk for recurrence given his poor prognostic markers such as the depth of the invasion and the presence of ulceration.

#### **RISK MANAGEMENT ADVISORY**

***This case basically dealt with an error of judgment by an examining pathologist in 2002 which led to a delayed diagnosis of an ongoing, serious condition involving melanoma until finally diagnosed in February 2003 by another pathologist. This subsequent pathologist examined the records and test results relied on by the defendant pathologist and concluded that the earlier review by the defendant constituted a deviation from acceptable standards of practice in failing to diagnose what he opined were clear signs of the melanoma that was not reported by the original pathologist.***

***Regarding the criteria for the evaluation of the actions of a specialist in misdiagnosing a serious condition to the peril of the patient, practitioners are reminded that physicians other than specialists may have some latitude in rendering an error of judgment in a diagnosis, particularly where the misdiagnosis was not totally unreasonable, and although not accurately diagnosing the condition as it ultimately turned out, the physician had reasonable belief that the condition was alternatively some other less offensive condition that the symptoms at that time could reasonably be determined to have indicated. However, such an error of judgment in-***

***voked in the defense of a practitioner having made a misdiagnosis cannot and usually is not invoked when dealing with such a misdiagnosis made by a specialist, such as the pathologist in this case.***

***In this regard, specialists are deemed to be responsible for a higher standard of care than the average non-specialist physician. That standard of care and its violation is judged by what would be appropriate for a specialist under those circumstances involved as being appropriate and proper for such a specialist. The evaluation as to deviation is testified to by experts in the particular field involved who are themselves specialists and who evaluate the conduct of the practitioner involved on the basis of that specialization and the necessary higher degree of care for which that physician is responsible, and not simply as an evaluation of a non-specialist where the standard of care may not, in fact, be as high as that of a specialist. Accordingly, what may well be a deviation from acceptable standards of practice for a recognized specialist acting in the course of his specialization may, in fact, not be a deviation on the part of a non-specialist, depending upon the particular nature of the misdiagnosis and/or the particular condition involved.***

***This case highlights that in a subsequent re-review of a pathology evaluation, or for that matter any test results such as x-rays, when the pathology not originally described has already become evident, the evaluators and experts know specifically what to look for. Such a reevaluation may not necessarily be a valid measure as to whether or not the failure to make an appropriate review and diagnosis at the earlier time when the condition was not definitive constituted clear evidence of deviation in failing to render an earlier and correct diagnosis under those circumstances. This is particularly so where the condition may not have originally deteriorated yet and where the parties did not have the benefit of hind-***

***sight in having available to them a later manifestation of the alleged original unnoticed condition.***

***In this regard, allegations of deviation for a failure to make a diagnosis should be judged on what was known at the time of the alleged deviation and not necessarily what was known at the time that the misdiagnosis was discovered relevant to the condition and its ongoing symptomatology. However, in this case, the original misreading of the pathology evaluation and slides was determined by appropriate pathology experts to have been clearly misread with clear indications of ongoing pathology that was missed by the accused pathologist. This professional judgment was rendered on the same criteria available to the accused physician and not judged on a re-taking of the test at a later time to determine whether or not the original evaluation constituted a misdiagnosis.***

***Practitioners should remember that in cases involving radiological and pathology evaluations by pathologists or any physicians being accused of a deviation in misdiagnosis, proof of later pathology on radiological findings are not necessarily sufficient proof of deviation in failing to evaluate what may have been less pathology and less definitive indication of pathology on the earlier x-rays or pathology reviews. However, in this case, the plaintiff was able to demonstrate a chronological history of the repeated complaints regarding the nail which were discounted by the various treating physicians as being benign in nature and inconsequential in effect due solely and exclusively to the erroneous pathology report. In this regard, the deviations alleged were confined to the actions of the pathologist.***

***Practitioners are reminded by this aspect of the case that when, as non-specialist general practitioners, they rely on the opinions of specialists, such reliance will not necessarily indefinitely justify continued ignoring of complaints of ongoing symptomatology so as to avoid an al-***

legation of deviation against themselves. Indeed, when symptoms persist over an unreasonable length of time, the non-specialist practitioner may have the legal obligation to question the prior specialist's diagnosis and order retesting or re-evaluation in light of the continuing and/or accelerating symptomatology under the original diagnosis. Said another way, what may have been reasonable reliance on an evaluation made by a pathologist or other specialist earlier, may well become an unreasonable reliance if, over an extended period of time, symptomatology increases which then puts into question the original diagnosis made by the pathologist or other specialist.

Practitioners who find themselves in situations where symptoms persist or even get worse under a previous diag-

nosis over a period of time should obtain the previous slides upon which the original specialist evaluation was made and have them re-evaluated to determine whether or not there existed an error in the original diagnosis that might account for the continued progression or worsening of the patient's condition. This re-review should also include, if necessary, a re-testing in situations where the original test results were not definitively clear or could be rendered more definitive.

In this regard, practitioners are reminded that as general practitioners who rely on specialist evaluations, they must be prepared to reasonably question such evaluations upon a delay in improvement or a progression of the symptoms over a period of time. A reliance on the prior evaluation of the specialist in the face of

continuing or progressing symptoms to the detriment of the patient can, in some instances, be determined a deviation from the acceptable standard of care. Faced with these circumstances, the prudent practitioner would be well advised to re-evaluate the prior testing by another qualified specialist, such as a pathologist in this case, or by an actual retaking of the test by another specialist in light of the increasing symptomatology that may not be justified necessarily under the pre-existing older evaluation.

#### REFERENCE

Massachusetts. Doe vs. Roe Pathologist. Case information withheld. Attorneys for plaintiff: Philip J. Crowe and Florence A. Carey of Crowe & Mulvey, LLP in Boston, MA.

## Additional Malpractice Verdicts by Specialty

### Oncology

#### PLAINTIFF'S CONFIDENTIAL RECOVERY - Failure to timely diagnose esophageal cancer - Cancer becomes inoperable.

This medical malpractice case involved the male plaintiff whose doctors missed the diagnosis of esophageal cancer. The plaintiff sued both the scheduler and examiner of his endoscopy after the oversight was discovered in a later exam. The plaintiff maintained that as a result of the defendants' negligence, the cancer advanced to the point where it became inoperable.

The evidence revealed that in 2005, the plaintiff underwent an endoscopy at Baylor Medical Center in Irving, TX. The biopsy of a portion of his esophagus was used to screen the plaintiff for certain cancers, including esophageal cancer. At the time, no cancer was diagnosed by the defendant pathologist who examined the biopsy results. The plaintiff's gastroenterologist, the co-defendant in this case, ordered another screen three years later. Upon receiving this endoscopy in 2008, the defendant pathologist discovered that the plaintiff now had highly advanced esophageal cancer. This

defendant's subsequent examination of past analysis, which is standard procedure, revealed that he had missed earlier signs of cancer in the 2005 screening. It was undisputed that the plaintiff's cancer was inoperable and incurable as of 2008.

The plaintiff filed suit on July 31, 2008, in Dallas County's 19th Circuit Court alleging medical malpractice against the defendant pathologist and co-defendant gastroenterologist. The plaintiff contended that had the co-defendant gastroenterologist scheduled the second biopsy for one year following and not three years following the first screening, his cancer would have been caught while it was still treatable. The plaintiff further alleged malpractice against the defendant pathologist for his failure to detect the plaintiff's cancer in the 2005 screening.

The plaintiff settled pre-trial for a confidential amount with the co-defendant gastroenterologist. This defendant admitted to the undiagnosed presence of esophageal cancer in the

earlier screen. Oncologist Dr. Frederic was deposed as a plaintiff's expert, but conceded that the cancer may have been too advanced in 2005 for a surgical cure at that time or a year later. Suit was subsequently dismissed against the defendant pathologist after a successful filing of a Daubert motion and a motion of summary judgment.

#### EXPERTS

Plaintiff's oncology expert: Rhett Frederic from Fort Worth, TX.  
Defendant's gastroenterology expert: Glen Eisen from Seattle, WA.

#### REFERENCE

Dallas County, TX. Lawrence Ward, III vs. Dr. J.K., et al. Case no. DC-08-08625; Judge Gena Slaughter. Attorney for plaintiff: Marc Stewart. Attorney for defendant Irving Laboratories and Dr. Ketchersid: William H. Chamblee. Attorney for defendant Dr. Katzman: Stan Thiebaud of Stinnett Thiebaud & Remington in Dallas, TX.

## Pathology

### **DEFENDANT'S VERDICT - Surgical sponge left inside decedent after laparoscopic hysterectomy allegedly contributes to her death - Pathologist performing autopsy allegedly conceals true cause of death by removing or chopping up internal organs.**

The plaintiffs, in this combined medical malpractice and desecration of a body case, claimed the defendant physicians who authorized and performed the requested autopsy on their mother were involved in a conspiracy to cover-up the true cause of her death. The family alleged their mother died from a surgical sponge that was left inside her during a hysterectomy, which caused her health to deteriorate in the months following, until her death. The family claimed emotional distress, burial expenses and past medical costs relating to the death of their mother. The defendants argued the decedent's death was the result of numerous underlying health conditions unrelated to the surgical sponge.

The defendants further alleged that a cover-up never existed, as evidenced by the fact that the family was immediately informed of the retained surgical sponge and that the medical examiner was initially contacted to perform the autopsy. The defendants maintained the autopsy was performed by the defendant hospital only after the medical examiner waived jurisdiction. The defendants contended the standard of care had not been breached and that the plaintiff's claims were unfounded.

The 68-year-old retired decedent presented to Sharp Grossmont Hospital in San Diego in April 2007 with a large mass in her pelvis. A laparoscopic vaginal hysterectomy was performed and following the surgery she developed an infection and was later diagnosed with peritonitis and an incarcerated hernia. 11 days later the decedent underwent a procedure to reduce the hernia and to address the infection. At this time, a surgical sponge was discovered and removed. The decedent slowly healed and was discharged.

In July 2007, the decedent presented at Alvarado Hospital where she died of kidney failure. The decedent's nine children, the plaintiffs in this case,

claimed their mother's decline began with the hysterectomy and the surgical sponge that was retained inside the decedent for ten days.

The defendants presented evidence that the overweight decedent had been ill for a long period of time previous to her death and that while her health began to deteriorate, she did improve after being discharged in the spring of 2007. The defendants argued that underlying health issues, such as high blood pressure and diabetes, contributed to her death.

The decedent spoke briefly with the defendant physician just prior to her death on July 12, 2007, and upon her death, the defendant requested an autopsy be done pursuant to the family's request. The co-defendant testified he phoned the medical examiner's office to inquire as to the office's intent to perform the autopsy. The medical examiner corroborated this testimony at trial, testifying that upon reviewing the decedent's medical records, his office waived jurisdiction on the basis that his office found no evidence of wrongdoing. The co-defendant pathologist then performed the autopsy at Alvarado Hospital.

In the co-defendant's autopsy report, he noted the retained surgical sponge found after the hysterectomy, but concluded it had no connection to the cause of the decedent's death. Upon receiving this report, the plaintiff's exhumed their mother's body and ordered a second autopsy with another pathologist. The physician who performed this autopsy claimed he was unable to find all the decedent's organs. Thus, the plaintiffs contended their mother's body was desecrated during the initial autopsy, which they claimed was evidenced by organs that were missing or evulsed.

The defendant's presented evidence that it is industry standard to keep some portions of the internal organs during an autopsy due to microscopic testing that is sometimes later performed on the organs.

The defendant's argued that upon exhumation, the internal organs quite possibly could have seemed congealed together due to the embalming process in which the organs are generally placed in a plastic bag inside the body cavity. Therefore, in accordance with industry standard, the internal organs would not be anatomically correct.

At trial, the plaintiffs presented pictures taken during the second autopsy, but the defendants argued the pictures were inconclusive and that they were provided no opportunity to perform their own post-exhumation examination. The defendants argued the plaintiffs failed to provide motive for a cover-up involving a procedure done at a competing hospital. The decedent underwent the hysterectomy at Sharp Grossmont Hospital and the autopsy was performed at the nearby Alvarado Hospital. The defendants argued the implausibility that they would risk their careers to attempt at covering up a malpractice at a competing hospital. Additionally, they contended the fact that the family was immediately notified of the sponge and that the sponge was noted in the autopsy report was evidence enough that a cover-up did not exist.

The hospital where the hysterectomy was performed and the defendant physician who performed the surgery settled the case, and the defendant was found not guilty on a non-suit dismissal. The co-defendant physician was found not guilty of malpractice after a ten day trial and two and a-half hours of jury deliberation.

#### **EXPERTS**

Plaintiff's pathologist expert: Dr. Marvin Pietruszka, M.D. from Reseda, CA. Defendant's hospitalist-internist expert: Dr. William Wayne Hooper, M.D. from San Diego, CA. Defendant's pathologist expert: Dr. Bernard S. Change, M.D. from San Diego, CA.

## REFERENCE

San Diego County, CA. Minyon Hamilton, LaVida Johnson, et al., individually and Successors in Interest to Margaret Griffin vs. Grossmont Hospital,

et al. Case no. 37-2008-00084918-CU-MM-CTL; Judge Timothy B. Taylor, 08-01-10. Attorneys for plaintiff: Joel G. Selik of Selik Law Offices in Encinitas, CA and Suzanne Mindlin in Carlsbad, CA. Attorneys for

defendant: Hugh A. McCabe and Andrew Chivinski of Neil, Dymott, Frank, Harrison & McFall APLC in San Diego, CA.

## Radiology

### **DEFENDANT'S VERDICT - Failure to timely order MRI with contrast - Delay in diagnosis and treatment of spinal abscess - Partial paraplegia.**

In this medical malpractice action, the plaintiff, a minister in his 60s, contended that the defendants failed to diagnose or delayed diagnosis of the plaintiff's spinal abscess causing the plaintiff to be rendered partially paraplegic. The defendants denied any violation of the standard of care and argued that the plaintiff's diagnosis and treatment was entirely appropriate given his presenting symptoms.

The plaintiff had been suffering back and jaw pain when he was first admitted to a local, community hospital where he was seen by number of physicians over the course of one week. MRIs of the plaintiff's spine were interpreted by a co-defendant and worked up for a number of possible diagnoses, including endocarditis. The plaintiff was kept in the ICU nearly the whole time he was at the community hospital. The plaintiff was then transferred to Beth Israel Hospital where he was seen by the defendant physicians late in the evening. The defendant resident worked up the plaintiff's case and did preliminary testing. The plaintiff appeared stable and had normal or near normal leg function at that time.

The following morning, the plaintiff was seen by the defendant attending hospitalist. The defendant hospitalist agreed with the defendant resident as to the plaintiff's condition and ordered further tests, including an MRI with contrast and other imaging of the plaintiff's jaw where the defendants felt the source of the infection might be located. The defendant hospitalist also ordered an echocardiogram to check the possibility of an infection of the heart. The defendant called specialists to

examine the plaintiff. All tests were carried out later that afternoon and evening.

The plaintiff began to show signs of a change in his lower body muscle strength and was sent for examination by the neurosurgery department. An MRI showed an abscess on the plaintiff's spine. The plaintiff underwent surgery for the abscess, but was nevertheless rendered partially paraplegic due to the abscess.

The plaintiff claims he can no longer perform home or hospital visits in his capacity as a minister due to ambulatory issues and that, due to a lack of strength and stamina, cannot do many activities he enjoyed before the subject injury. The plaintiff asserted that an MRI with contrast should have been performed when he was first admitted to the community hospital and, when that was not done, the defendants at Beth Israel should have ordered on the MRI with contrast on a stat basis based on the plaintiff's presentation.

At trial, the plaintiff called a radiology expert who testified that the co-defendant radiologist should have looked at prior images that were available at the community hospital and, if he had, he would have seen a change that would have even further indicated the need for an MRI with contrast. According to the plaintiff's expert, the previous images alone indicated the likelihood of an abscess rather than discitis. The plaintiff called a neurosurgeon who testified that the appropriate tests, including an MRI with contrast, should have been done earlier at the community hospital. The plaintiff's expert opined that the plaintiff's symptoms indicated that further imaging was required. Further, according to the

plaintiff's expert, once the plaintiff had been transferred, the defendants should have imaged the plaintiff with MRI with contrast on a stat basis. The plaintiff's expert testified that, had that happened, the plaintiff would have gone to surgery sooner and his lower extremity function would have been preserved.

The defendants argued that the plaintiff's clinical exam showed normal function and strength in the lower extremities and thus, there was no indication for an MRI with contrast. At the community hospital, the plaintiff underwent cultures which found an infectious streptococcal organism. The defendants argued that streptococcal infections are almost exclusively confined to the mouth and neck, indicating that the likely origin of the plaintiff's complaints was not the spine, but rather the neck or mouth. This diagnosis was bolstered by the plaintiff's complaints of jaw pain and loose dental hardware.

The defendants maintained the plaintiff presented with an oral pathogen that would indicate the source of infection was in the mouth. Since no imaging of the jaw had been performed at the community hospital, the imaging of the mouth was the defendants' first priority. Imaging of the mouth was followed by an echocardiogram and an MRI with contrast which were deemed necessary, but not acutely, based on the plaintiff's clinical exam. Further, the defendants had the plaintiff's MRI from the community hospital and it was shown to a neuroradiologist who did not indicate any urgency for an MRI with contrast.

The defendants asserted that the plaintiff's presentation indicated discitis as opposed to abscess and discitis is treated

non-surgically. The defendants concluded that all appropriate treatment was given to the plaintiff and there was no way to predict or avoid the plaintiff's outcome. At trial, the defendants presented an expert hospitalist who testified that he agreed with the defendants' decisions and choices. The defendants' expert stated that, given the plaintiff's presentation, there was a great degree of likelihood that the origin of his infection was in the mouth. The defendants' expert opined

that all appropriate specialists had examined the plaintiff and none felt it likely that he had an abscess. The defendants' expert also noted that the plaintiff was diagnosed and in surgery within 20 hours which, he opined, was extremely quick handling of the plaintiff's illness and gave him the best possible outcome.

The jury found no negligence by any defendant and returned a verdict in favor of all defendants.

## REFERENCE

Suffolk County, MA. Christensen, et al. vs. Dr. K., et al. Case no. SUCV2005-05437, 3-29-10. Attorney for defendant Li (as amended): George E. Wakeman, Jr. of Adler, Cohen, Harvey, Wakeman & Guekguezian, LLP in Boston, MA.

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# Medical Practice Liability

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## Business Practices/Unfair Competition

### **AN ARBITRATION AGREEMENT SIGNED BY A PATIENT UPON ADMISSION TO A NURSING FACILITY WAS AN UNENFORCEABLE CONTRACT OF ADHESION BECAUSE THE PATIENT HAD NO OTHER OPTIONS AND WAS IN PAIN AT THE TIME.**

An arbitration agreement signed by a patient upon admission to a nursing facility was an unenforceable contract of adhesion because it was given to her on a "take it or leave it" basis while she was in pain and had no alternative choices, according to a recent Tennessee appellate court holding.

The female plaintiff, 61 years old, underwent extensive spinal surgery at St. Thomas Hospital. When released she was transported by ambulance to Christian Care Center, a skilled nursing facility for convalescence and rehabilitation. She testified that she was in severe pain prior to getting into the ambulance and that the jolting during the ambulance ride worsened her pain. Medical records from St. Thomas showed she was given a tablet of Lortab for hip pain on the morning of her release and another for back pain shortly after. The medication apparently did not relieve her pain since she scored her pain intensity as a 10 out of 10 after each dose. She was also medicated with Valium and given two additional Lortabs for back pain just before she was placed in the ambulance.

Soon after arrival at Christian she was approached by the admissions coordinator. The plaintiff testified that

she asked for pain medication, but was told no medication could be administered until she completed the admissions process. The admissions packet included a six page arbitration agreement that read: "This agreement waives resident's right to a trial in court and a trial by jury for any future legal claims resident may have against facility." The plaintiff signed the agreement, but the admissions coordinator did not provide her with a copy. A few hours later, the plaintiff fell in the bathroom resulting in a compound fracture of her ankle and the bursting open of her surgical wound. She was taken for surgery and remained hospitalized for more than 30 days. She had rods placed in her ankle and remains incapacitated.

The plaintiff filed a malpractice action against Christian which, in turn, filed a motion to compel arbitration. The trial court found that the arbitration agreement had been presented on a "take or leave it basis," that the plaintiff had no choice but to sign it, and that the defendant's failure to provide copies of the agreement made it probable that the plaintiff was unaware of her right to rescind. It concluded it would be unconscionable to enforce the arbitration

agreement and this ruling was affirmed on appeal. The appellate court explained that the circumstances justified a finding that the arbitration agreement was an unenforceable contract of adhesion.

## COMMENTARY

A contract of adhesion may exist where a standardized form is given to a patient to sign on a "take it or leave it" basis without affording a realistic opportunity to bargain and under conditions where the patient cannot obtain the service except by acquiescing to the form contract.

This case involved a standardized contract form and there was no suggestion that the plaintiff had the opportunity to bargain for different terms. One clause stated, "If you do not believe binding arbitration is the right choice for you, we will, upon written request, reasonably assist you in finding other nursing facilities in the area or other long term care options such as home care or assisted living facilities."

The proof showed that the plaintiff was a Medicare and Medicaid patient with limited options. There was no nursing facility in her home town that would accept her insurance, and the defendant

was one of only two facilities in the county that accepted patients in her position. The other facility had declined to admit the plaintiff because of her weight. The proofs also showed that because of her pain, the plaintiff wanted to get the admissions process over with so she could lie down and take some pain medication. In the appellate court's view, under these circumstances, the plaintiff's only realistic choice was to sign the document.

The nursing home argued that the arbitration agreement was not a contract of adhesion because of a provision giving the plaintiff the right to revoke it by giving written notice of her intention to do so within 30 days. It further asserted that the admissions coordinator did not say anything to indicate that the plaintiff would be discharged from the facility if

she revoked the agreement and that in any case, a discharge for such a reason would be unlawful. However, the plaintiff had no opportunity to bargain over the terms of the standardized form contract which was presented to her on a "take it or leave it" basis. Under the circumstances, the language about helping her find other nursing facilities in the area was found to be, at best, "a hollow promise" and, at worst, "a veiled threat."

***In general, agreements to arbitrate disputes are favored because arbitration may allow parties to avoid the formalities, delay, expense and vexation of trial court litigation. However, an arbitration agreement may be found to be a contract of adhesion if there is unfairness in the formation of the contract such that one party is***

***deprived of meaningful choice (e.g., if the contract is presented to a party on a take it or leave it basis and the party is not given the opportunity to understand the agreement) or if the terms of the contract are unreasonably favorable to the drafting party. A court will usually closely scrutinize an alleged contract of adhesion to determine whether mutuality did not exist when entered into and whether the agreement imposes unconscionable terms on the less powerful party.***

#### REFERENCE

McGregor v. Christian Care Center of Springfield, L.L.C., 2010 WL 1730131 (Tenn. App. 2010).

## Informed Consent

### **A PHYSICIAN WHO PERFORMED THE SAME BACK SURGERY ON A PATIENT A SECOND TIME SOON AFTER THE FIRST PROCEDURE MAY HAVE FAILED TO OBTAIN HIS INFORMED CONSENT TO THE SECOND SURGERY.**

A physician who performed a second laminectomy/discectomy on a patient shortly after performing the first procedure may have failed to obtain the patient's informed consent to the second procedure, according to a recent Ohio appellate court decision.

The defendant performed a laminectomy/discectomy on the plaintiff who then reinjured the same disc a few months later. Prior to the second surgery, the defendant allegedly failed to disclose the significant additional risks associated with performing the exact same surgery again (e.g., that the existing scar tissue from the old surgery would likely complicate the procedure and the likelihood that pain would be much greater after the second surgery compared to the first). The second surgery left the plaintiff with permanent chronic pain which required him to take heavy narcotic medications.

The plaintiff filed an action against the defendant alleging he failed to obtain his

informed consent to the second surgery. The evidence presented during the trial revealed the defendant knew that the second surgery carried a much greater risk of a poor outcome than the first; though he did not mention the greater risk(s) associated with the second surgery; that the plaintiff's condition was significantly worse after the second surgery; and that the second surgery was the most likely cause of his deteriorated condition.

The defendant moved for a directed verdict which was granted. However, this ruling was reversed on appeal. The appellate court explained that the evidence, for instance the defendant's failure to note on the hospital report that he had obtained the plaintiff's informed consent, could have led to a finding in favor of the plaintiff.

#### COMMENTARY

Generally, a claim for failure to obtain a patient's informed consent is established when a physician fails to disclose and discuss material risks or dangers that are

associated with a proposed medical treatment or procedure; the undisclosed risk or danger actually materializes, and is the proximate cause of the patient's injury; and the patient or a reasonable person would have declined the treatment or procedure in the event that the physician had properly apprised him of the potential risks involved.

Reviewing the evidence the appellate court found that it could have supported a conclusion that the defendant failed to obtain the plaintiff's informed consent to the second surgery. For example, his office notes tended to corroborate the plaintiff's testimony, because they failed to mention any disclosure of the additional risks associated with the second surgery. The court elaborated that the subject of the lengthy discussion between the plaintiff and the defendant was related to pros and cons of having the surgery and its timing. The inferences drawn from the office notes were also confirmed by the hospital pre-procedure forms, in which the defendant signed his name and

checked the “yes” box indicating that he had received the plaintiff’s informed consent before the first surgery, but, on the form completed prior to the second surgery, he did not indicate that he received the plaintiff’s informed consent. This pattern was duplicated in the hospital’s operative reports. In the report from the first surgery, the notations indicated as follows: “The risks of the procedure were explained to the patient, and he requested the procedure after the failure of conservative care.” There was no similar notation in the operative report

from the second surgery. Although the defendant did testify that he obtained the plaintiff’s informed consent to performing the second surgery, he did acknowledge the risks associated with a second laminectomy/discectomy were significantly higher than they were with the same procedure when it was performed for the first time.

**A patient’s informed consent usually has to be obtained by a physician prior to each procedure performed. When a second procedure, even the same one, is performed on a patient,**

**a physician cannot rely on disclosures and consent forms from the prior procedure. Not only may the risks be different with the second procedure, but even if they were exactly the same, informed consent procedures (disclosure of risks and alternatives, and obtaining signed consent forms) should nonetheless be followed anew.**

#### REFERENCE

White v. Leimbach, 2010 WL 1544410 (Oh. App. 2010).

## Peer Review

### A CHIROPRACTOR WAS DISCIPLINED FOR A LARGE NUMBER OF BILLING ERRORS RELATED TO A PATIENT EVEN THOUGH BILLING WAS PERFORMED BY STAFF IN THE PRACTICE.

A chiropractor was properly disciplined by a professional board for a large number of billing errors relating to a patient even though billing was performed by staff and he was not familiar with billing, a California appellate court has ruled.

The patient filed a workers’ compensation claim that was handled by Highlands Insurance Company. A month later, he sought treatment from the defendant for the back injury he sustained. He had over 160 treatments for his back injury over approximately two years. He then sustained another industrial injury, exacerbating his back injury. He filed another workers’ compensation claim, which was handled by Superior National Insurance Company. Again, he obtained over 100 treatments from the defendant over the course of two years. He testified that the treatments alleviated his symptoms.

This patient was the only one during the defendant’s 20-year practice to be treated simultaneously for two industrial injuries at two different job sites covered by two different insurers. The complexity of the billing led to mistakes by an inexperienced billing clerk. For a while, the defendant’s wife assumed responsibility for billing, hiring and

training staff. As far as the defendant and his wife were aware, staff billed competently. They never received any complaints or notification from any insurer indicating error on a bill.

Eventually, the defendant was deposed in one of the patient’s workers’ compensation cases. An attorney representing the insurer accused him of billing irregularities. Although the defendant instructed his wife to audit the patient’s bills, it revealed approximately 114 billing errors, some in favor of the respective insurer and some not. The defendant’s wife sent the correct billings to the insurance company in August 2002. The defendant and his wife both testified that he had very little to do with the billing practices in his offices. He did not know most of the codes they were required to use and relied on his staff to bill for his services.

A disciplinary proceeding was commenced by the California Board of Chiropractic Examiners. Following a hearing, an administrative law judge (ALJ) made findings later adopted by the Board. As to billing, the ALJ found the defendant failed to ensure the accuracy of his billings and that this constituted in aggregate, gross negligence. The ALJ further reported that the approximately

114 billing errors included double billing (both insurance companies billed for the same treatment), billing of incorrect CPT codes, billing the incorrect carrier, and billing for services not rendered on a particular date of service. The ALJ concluded there was cause for discipline for commission of acts of gross negligence in billing insurers.

The Board then revoked the defendant’s license, but stayed the revocation and instead imposed a three-year term of probation, and directed him to reimburse the Board for costs of \$72,242. These rulings were then affirmed on appeal. The appellate court agreed that the defendant was responsible for the large number of billing errors arising from his practice and that the disciplinary measures taken were appropriate.

#### COMMENTARY

Health care providers are, as a rule, responsible for presenting accurate billing for their services. A California administrative regulation provides that: “[i]n the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling . . . Failure by the licensee, within 30 days after discovery or notification of an error which resulted in

an overbilling, to make full reimbursement constitutes unprofessional conduct.”

The defendant contended that the final sentence of this regulation provided a safe harbor, that is, a chiropractor remained immune to charges of professional misconduct relating to billing provided he corrected the errors and made full reimbursement during a 30-day grace period. In his view, he was wrongfully denied the benefit of this “safe harbor” based on the erroneous finding that he was notified of the errors at the deposition in May 2002, rather than at the completion of his in-house audit in July.

However, the appellate court found that the regulation did not provide a 30-day safe harbor for negligent billing. The court explained that whether the insurers brought the billing to the defendant’s

attention was irrelevant to his duty to prevent them from occurring in the first place. In addition, the court interpreted the regulation to mean that chiropractors had 30 days to correct errors; rather, it stated that the failure to correct errors within 30 days constituted unprofessional conduct. Thus, if the Board had evidence the chiropractor either discovered or was notified of an error and did nothing to correct it within 30 days, that in itself was unprofessional conduct. In short, the last sentence spoke to a failure to act once an error was discovered but did not exonerate a chiropractor for gross negligence or repeated acts of negligence relating to billing practices.

**A health care office may have staff responsible for many aspects of its operation including billing. However, a**

**professional board may hold the health care professional personally responsible for mistakes made by employees acting on his behalf and on the behalf of his practice. Accordingly, a health care professional may have the obligation to supervise all aspects of his practice in such a manner that professional negligence, including billing, does not occur.**

#### REFERENCE

Davis v. Board of Chiropractic Examiner’s, 2010 WL 1434322 (Cal. App. 2010).

## Defensive Actions/Countermeasures to Malpractice Suits

### AN OPINION EXPRESSED BY THE PLAINTIFF’S EXPERT THAT WAS DIFFERENT FROM WHEN HE WAS THE PATIENT’S TREATING UROLOGIST HELPED UNDERMINE HER CLAIM THAT A SURGEON NEGLIGENTLY TREATED HER CYSTOCELE.

An opinion expressed by the plaintiff’s expert that was different from when he was her treating urologist helped undermine her claim that a surgeon negligently treated her cystocele, the U.S. Fourth Circuit Court of Appeals has held.

The plaintiff suffered from a cystocele in which the fascia (soft tissue) between the bladder and the vagina degraded such that the bladder bulged into the vagina. A surgeon employed by the U.S. government performed surgery that afforded temporary relief. However, 20 months later, the plaintiff again experienced pain and the surgeon concluded her cystocele had recurred. He performed an anterior colporrhaphy, holding open the vagina with a speculum while looking in to locate the cystocele. He then cut the anterior vaginal wall to

reveal the fascia and used sutures to pull together and reinforce strong fascia before closing the vaginal wall.

A week after surgery the plaintiff called her surgeon’s office complaining of pain and requesting medication, which she received. A week later, a renal ultrasound revealed “gross hydronephrosis,” (the plaintiff’s kidney was swollen and her ureters were likely obstructed). The surgeon referred the plaintiff to another physician who noted in his operative report that the plaintiff’s ureter was deviated, which suggested swelling. He also noted that the ureter was obstructed to the point where he could not pass a sensor wire through it to determine the location of the blockage.

The next day, the plaintiff went to West Virginia University Hospital. First, a

urologist, attempted to correct the ureteral blockage using a stent. That attempt failed, leaving surgery as the only option. To allow the plaintiff’s kidney to drain prior to surgery, another doctor placed a tube into the kidney to release the excess fluid into a bag. She noted that the plaintiff’s ureter inserted ectopically (in the wrong place) into the bladder. A surgeon performed ureteral reimplantation surgery (cutting the ureter near the obstruction and then re-inserting it into the bladder, effectively bypassing the blockage) which solved the problem.

The plaintiff filed an action against the U.S. under the FTCA, with West Virginia law applying. Her complaint advanced two theories of liability: 1) that the original surgeon had stitched in a negligent manner causing an obstruction

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to her ureter; and 2) that he had negligently failed to perform a cystoscopy to check for ureteral obstruction.

After expert testimony was offered by the plaintiff's expert (the urologist who had treated her) and by the defendant, the trial court found that the plaintiff failed to establish that a misplaced stitch, standing alone, breached the applicable standard of care. It also found that she failed to establish that a surgical stitch caused her ureteral obstruction. It also found that the standard of care did not require physicians to perform an invasive diagnostic procedure to evaluate the ureters during an anterior repair surgery.

The resulting judgment was then affirmed on appeal. The appellate court found sufficient evidence to justify the trial judge's decision including that the opinion of the doctor serving as the plaintiff's expert was not that expressed by him as her treating urologist, requiring corroboration to be credible.

#### COMMENTARY

Generally, in a malpractice action the plaintiff has to establish, through the use of expert testimony, both the standard of care, that the treating physician's actions breached that standard and that the

breach was the proximate cause of the injuries suffered. The trial court found that a doctor's placement of a stitch through a ureter, in and of itself, did not violate the standard of care. According to the appellate court, there was strong support for this finding. The plaintiff's own expert, although of the opinion that negligence arose when a physician failed to perform an invasive diagnostic procedure to check whether he stitched incorrectly, conceded that an errant stitch, standing alone, did not breach any applicable standard of care.

With regard to causation, the trial court found that the plaintiff had not established that a stitch had obstructed her ureter. Again, the testimony of her own expert acknowledged that he had not personally seen a stitch in the plaintiff's ureter. Instead, he stated that the other possible causes of a blockage to the ureter (edema, a congenital structure and kidney stones) were relatively unlikely. The trial court also found the process-of-elimination rationale that edema could have caused the blockage, and that an ectopically inserted ureter might also have caused the problem by the plaintiff's expert unpersuasive. It also found the expert's testimony not entirely

credible because the doctor the plaintiff's treating urologist, had not voiced any concerns about a surgical stitch until after she had retained him as an expert witness. The trial court found that this shift in views "cast a shadow of doubt on the objectivity of his reports," and thus diminished the weight of his testimony. He conceded that he did not see any stitch, but rather concluded that a stitch probably caused the blockage because, in his opinion, other causes were unlikely. However, absent some concrete proof, his reasoning was only as persuasive as the trial court found his testimony credible.

***A treating doctor may appear as an expert witness for a malpractice plaintiff. However, in assessing his credibility, the trial court may compare the opinions he held while functioning as a treating doctor and while functioning as an expert witness. If the two differ, then this doctor's credibility as an expert may be adversely affected requiring additional corroboration.***

#### REFERENCE

Drennen v. U.S., 2010 WL 1650032 (4th Cir. 2010).

## New/Expanded Liability

### DISCOVERY WAS ORDERED OF REDACTED CHARTS OF SIX PATIENTS ON THE SAME FLOOR AS A HYSTERECTOMY POST-OPERATIVE PATIENT TO SEE IF THEIR "ACUITY" JUSTIFIED THE HOSPITAL'S NURSING STAFFING DECISION.

Discovery was ordered, by the Supreme Court of Utah, of the redacted charts of six patients on the same floor as a hysterectomy patient whose blood pressure fell postoperatively to help determine whether their "acuity" justified the hospital's nursing staffing decision.

The plaintiff underwent a hysterectomy at St. Mark's Hospital. Following surgery, she was sent to floor Four West for postoperative recovery. She was cared for by a registered nurse who had an additional six patients during that same evening. St. Mark's nursing guidelines suggested a minimum of six registered

nurses be on duty if there were 34 patients to a floor. These guidelines also provided that if a patient's systolic blood pressure dropped below 90 points, the patient's assigned nurse had to report that drop to the patient's physician. Four West was staffed with only five registered nurses and had a total of 34 patients on the evening after the plaintiff's surgery. During that evening, the plaintiff's systolic blood pressure dropped from 132 to 86 and her physician was never notified.

The plaintiff filed an action against St. Mark and others, claiming that the nurse

assigned to her was negligent and that St. Mark's knowingly and recklessly understaffed floor Four West, and that because of this understaffing, the defendant nurse was unable to adequately monitor and prevent damage to her kidneys resulting from the low blood pressure. To support her negligent staffing claim, the plaintiff requested documentation reflecting the acuity (i.e., the amount of nursing care a patient required) of the other patients assigned to the nurse during the evening following her surgery.

Eventually, St. Mark's was ordered to produce either a chart reflecting the acuity of these patients or a statement discussing how patient acuity was assessed and communicated on floor Four West. St. Mark's chose the latter. It produced an affidavit of the nursing manager for floor Four West, who explained that patient acuity involved multiple factors including the patient's medical diagnosis and needs that changed from shift to shift. She also indicated that she had personally reviewed the six patient charges assigned the nurse responsible for the plaintiff and that in her opinion, it was an appropriate staffing decision.

The plaintiff then requested the six patient charts, arguing it would be unfair for the nursing manager to have access to these charts without providing her an opportunity to review them too. St. Mark's refused, relying on physician-patient privilege. To overcome this objection, the plaintiff stipulated to redaction of all personal identifying information from these charts as well as limiting their review to only attorneys and experts. St. Mark's rejected this stipulation.

However, the court ordered St. Mark's to produce the charts for redaction and limited review. This ruling was then affirmed on appeal. The appellate court concluded that the six patient charts redacted of all identifying information for limited use in this litigation did not violate the physician-patient privilege.

#### COMMENTARY

In essence, the defendant contended that the physician-patient privilege (contained in Utah's rules of evidence) permitted neither redaction nor restricted review of patient medical files; and that even if redaction were allowed, the patient files would be only marginally relevant to the plaintiff's negligent staffing claim and, therefore, would not overcome its interest in protecting patient privacy. The defendant responded that any redaction would not change the privileged character of the records.

However, the appellate court sided with the plaintiff in this case. In its view, without an identified individual connected to a diagnosis, the diagnosis contained nothing more than medical terminology.

The court pointed to decisions in other jurisdictions that had come to similar conclusions. It rejected the defendant's contention that due to the sensitive nature of one's medical records, a patient's candid disclosure could be chilled if the patient believes there was a possibility of being identified even after redaction.

***The physician-patient privilege is intended to foster candor by promising protection of confidential disclosures. The purpose of the privilege is to promote full disclosure by a patient to a physician to facilitate more effective treatment. Yet, exceptions to the privilege exist and a court may decide that discovery of patient charts redacted of any information that would identify individual patients, confirmed by a judge's review of the redacted records, might not jeopardize the protection afforded by the privilege.***

#### REFERENCE

Staley v. Jolles, 2010 WL 1133334 (Ut. 2010).

## Insurance

### **CLAIMS FOR PAYMENT OF MEDICAL SERVICES PROVIDED BY A PHYSICIAN-HOSPITAL ORGANIZATION AGAINST SEVERAL INSURERS AND HEALTH PLANS WERE SUBJECT TO THE LIMITATIONS PERIOD GOVERNING OPEN ACCOUNTS, RATHER THAN THE PERIOD FOR CONTRACT ACTIONS.**

Claims by a physician-hospital organization against several health care plans and insurers were subject to the statute of limitations governing open accounts rather than the statute governing contract claims, according to a recent Louisiana appellate court decision.

Touro Infirmiry submitted claims for medical services rendered to patients who were enrolled as members of certain health or insurance plans provided by the defendants. Touro alleged that all of these patients through their relationship to the defendants were part of the MultiPlan, Inc. preferred provider system in which Touro participated as a physician-hospital

organization known as Choice Healthcare PHO. Choice contracted with third parties including physicians and hospitals such as Touro. Choice entered into a contract with Multi-Plan, inc., a national preferred provider organization. Touro as a member of Choice was bound to accept payments at discounted rates for medical services for MultiPlan's clients in exchange for the prospect of increased patient volume. As members of this system the patients were entitled to receive medical services at pre-negotiated discounted (alternative) rates.

Touro filed an action against the defendants to obtain reimbursement at

the full "usual and customary rate" rather than the discounted rate. Touro alleged that the benefit cards of the patients in question did not identify the preferred provider organization as required by Louisiana statute and that, as a result, Touro billed for services rendered to their patient enrollees at the usual and customary rate, rather than the discounted rate. Touro further alleged that the defendants improperly reimbursed it at the MultiPlan alternate rates. The defendants responded that the claims were barred by the statute of limitations. Touro argued these claims were subject to the ten-year limitations period applicable to contract claims while

the defendants argued the claims were subject to a three-year limitations period for open account claims.

The defendants moved to dismiss the claims. The trial judge decided in their favor and this ruling was affirmed on appeal. The appellate court concluded that the claims were open account claims subject to a three-year statute of limitations that had already expired.

#### COMMENTARY

In jurisdictions such as Louisiana, charges by medical providers for services are generally characterized as open account claims, and the fact that a patient may have been treated on only one occasion would not alter the open account character of the transaction. A Louisiana statute defined “open account” as “any account for which a part or all of the balance is past due, whether or not the account reflects one or more transactions and whether or not at the

time of contracting the parties expected future transactions [and] shall include debts incurred for professional services, including but not limited to, legal and medical services.”

According to the appellate court, the fact that there may have been an agreement to bill MultiPlan patients at a certain agreed upon discounted rate did not change the nature of this claim from open account to contractual for purposes of the applicable statute of limitations. The court explained that the plaintiff could not argue that even if the action was based on an open account, it was also a contract action and, as such, there was the option to establish the claim under the contract theory subject to a 10 year limitations period. This choice did not exist since an action on open account, while arising from a contractual relationship, was an established exception to the general limitations period. Louisiana courts have uniformly rejected

attempts to circumvent three-year limitations period applicable to action based on an open account by categorizing the action as one for breach of contract.

***A statute of limitations sets the time frame in which a claim must be brought. A dispute may arise between a provider of medical services and an insurer as to the statute of limitations to be applied to certain medical claims. The resolution of this issue, based on local statutes and how they have been interpreted by local courts, that could range from a short to a long limitations period, could be decisive in determining whether a claim can be pursued as timely or has been forfeited due to delays allowing the limitations period to lapse.***

#### REFERENCE

Touro Infirmary v. American Maritime Officer, 2010 WL 46526 (La. App. 2010).

NOTES:

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