

A Message from the President

It is with great sadness that I am approaching the end of my tenure as president. It has truly been my pleasure to work with our members and this very talented board of directors.

I must give special thanks and recognition to Mike Midgley, our President-Elect, and the Chair of the Education Committee this past year. Mike has made my job very easy by planning and executing all of our excellent, well-attended conferences this year. In the face of the looming economic crisis, and changing times, I believe that the conferences and venues have been of consistent high quality. This makes me very proud!

Our annual (full day) conference will be held on Friday, June 12th, as it traditionally coincides with the launch of Healthcare Risk Management week. Again, I invite you to join us for a full day of renowned speakers, and an agenda dedicated to looking at how the volatile economy is impacting healthcare, risk management, and YOU!

I look forward to seeing you there.

Grace R. Langan, R.N.

President

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PREPARING FOR AN OPMC INTERVIEW

By: Theodore F. Goralski, Jr., Esq.

Among the variety of issues healthcare risk managers are called upon to deal with on an everyday basis are issues regarding the credentials of the organization's professional employees. Beyond insuring proper credentialing in the hiring process, health care organizations have been interested in maintaining the good standing of its professionals employees. State actions to discipline physicians and other professionals can be costly to organizations in a variety of ways not the least of which is the damaged reputation associated with publicity surrounding disciplinary action.

Preparation for the disciplinary process requires knowledge of the definition of misconduct, familiarity with the process and a great deal of time. This article will first discuss legal definitions of misconduct. Second, we will discuss preparation for OPMC interviews and the interview itself. Finally, we will describe the potential outcomes of the interview.

OVERVIEW

Although issues of physician discipline by the state seem to have been replaced on the front page of our newspapers by recent financial worries, the media attention to medical misconduct over the past couple of years continues to resonate in the health care community. The Department of Health, stung by public criticism, has increased its efforts to ensure public safety by investigating increasing numbers of medical care providers. The State is casting a wider net using more and more sources of information to initiate investigations rather than merely relying on patient complaints. The most relevant of these to health care risk managers are medical malpractice actions and events which require reporting to the Department of Health under the NYPORTS system. An effective risk manager, whether in a hospital setting, group practice or other setting can best serve his/her organization by knowing how to guide doctors and other professionals through the disciplinary process when necessary.

Licenses for physicians in New York are issued by the Department of Education. The State Education Law contains specific definitions of misconduct. The regulation of physicians and other professionals,

however, falls under the Department of Health. The Office of Professional Medical Conduct is the enforcement arm of the Department of Health. The Office of Professional Medical Conduct (OPMC) is required by law to investigate every complaint or incident reported to it no matter what source. Sources of complaints range from disgruntled patients or lawyers prosecuting lawsuits to mandatory hospital reporting to the Department of Health in the NYPORT system. Recently, the OPMC has been more aggressive in actively reviewing judgments and settlements of medical malpractice actions as reported by insurance companies. Although required to investigate every complaint or incident reported to it, OPMC has the discretion to close its investigation at any time, and, in fact, many investigations are closed without the medical professional involved ever knowing that an investigation has taken place.

DEFINITIONS OF MISCONDUCT

Professional Misconduct is defined by New York State's Education Law § 6530. The numerous subsections identify over 48 specific categories of misconduct. The majority of OPMC investigations fall within the categories of negligence and incompetence. These sections define professional misconduct as either practicing medicine with gross negligence on one occasion or practicing medicine negligently on more than one occasion. Similarly, practicing the profession with gross incompetence on one occasion or practicing with incompetence on more than one occasion also constitutes misconduct. Incompetence is distinguished from negligence, as the lack of skill or knowledge necessary to practice the profession as opposed to a specific departure from a standard of care.

FRAUD

The first categories listed in the Education Law involve fraud. A fraudulent license should be discussed during the hiring and/or credentialing process. Practicing fraudulently is a broader category and can include such acts as improper billing and alteration of records. These are self evident and require little explanation.

IMPAIRMENT BY DRUGS, ALCOHOL, PHYSICAL OR MENTAL DISABILITY

Practicing a profession while impaired by alcohol, drugs, physical disability or mental disability is also misconduct. Certainly no one would dispute that treating patients while “under the influence” is improper. Risk managers must ensure that a zero tolerance policy is in place. Take, for example, a surgeon who is on call and goes out to dinner with friends. While one or two glasses of wine with dinner may seem harmless, a call from the emergency room places that doctor in a difficult position. The right choice, of course, would be at that point to find another surgeon to perform the emergency procedure. Keep in mind that if the surgeon makes the wrong decision and proceeds with the procedure he is guilty of misconduct even if the patient is not harmed. Moreover, a colleague who is aware of the fact that the surgeon has had a couple of drinks is also under the obligation of law (Public Health Law Section 230(11)(a) to report any professional misconduct to OPMC. In fact the failure to report misconduct is itself one of the definitions of misconduct.

Physicians may also be deemed impaired by a physical or mental disability. Impairment is measured by the effect the impairment has on patient care. An individual with a disability is not prohibited from practicing, however, care must be taken to ensure in fact that patient care is not affected by any such disability.

HABITUAL ABUSE OF ALCOHOL OR DRUGS

Habitual abuse of alcohol or drugs is a separate category of misconduct. This definition of misconduct covers a situation where the use of alcohol or drugs does not necessarily impair the ability to practice. The mere existence of a chronic problem with alcohol or drugs can itself be the basis of disciplinary conduct by the State.

CONVICATION OF A CRIME

A physician who enters a guilty plea or is found guilty of a crime by the State of New York, a Federal Court or the Court of another state or country is guilty of misconduct. In these cases the physician is not permitted to re-litigate the underlying acts. The hearing is limited to a determination of the severity of the penalty to be imposed upon the licensee. Penalties are

discussed below. Crimes in New York are divided into felonies and misdemeanors. Other minor violations, such as traffic tickets or disorderly conduct, do not rise to the level of a crime. Prosecutors routinely report convictions of crimes by physicians to OPMC and physicians are required to disclose convictions upon re-registration. This all means that the medical professional who finds him or herself in trouble with the law should consult, not only with a criminal law attorney, but with health law counsel prior to a plea bargain in order to review all implications.

IMPROPER PRESCRIPTION OR ADMINISTRATION OF CONTROLLED SUBSTANCES

Article 33 of the Public Health Law covers controlled substances. All healthcare providers should be familiar with these laws. Physicians should not be writing prescriptions for spouses, family or friends who are not the physician’s patients. The dilemma is that when such an issue comes before the OPMC the question arises as to the availability of a medical record if the person for whom the drugs were prescribed was a patient. Failure to treat a patient without keeping their contemporaneous medical chart is also an area of misconduct.

PERMITTING AN UNLICENSED PERSON TO PERFORM ACTIVITIES REQUIRING A LICENSE

In addition to the obligation to report misconduct as stated above, it is also misconduct to permit, aid or abet an unlicensed person to perform activities requiring a license. Modern medical practice involves the integration of various professionals including various levels of expertise. Physical therapy assistants have a more limited scope of practice than physical therapists. This is true in areas of respiratory therapy, occupational therapy, nursing as well as other areas of medical care. With various pressures on organizations in the financial reimbursements period, there is a temptation to blur the lines of these areas. A physician, as captain of the ship, is responsible for these transgressions and can be found guilty of misconduct. Risk managers should be responsible to ensure that these lines are not crossed.

REPORTING REQUIREMENTS

As stated above, there are various sections requiring the reporting of misconduct. Physicians should be aware of

Public Health Law Section 230(11) and Public Health Law Section 2803(a). A physician is obligated to report to OPMC any information which “reasonably appears” to show “that a licensee is guilty of professional misconduct”. A physician is protected from an action for civil damages such as defamation if the report is made in good faith and without malice. Even if the physician is reasonably unable to determine if information constitutes misconduct, there is still an obligation to notify OPMC and request their advice on the matter. This can be done without disclosing the name of the subject physician or professional. Similarly, there are obligations to notify the hospital where the physician is affiliated and to the medical society of which the physician is a member. A physician is not required to violate any physician-patient confidentiality with regard to this section.

VIOLATION OF LAWS

There are a variety of laws, rules and regulations governing the practice of medicine and violation of any such enactments constitute misconduct. These include Medicare and Medicaid anti-kickback statutes (42 U.S.C. 1320a-7b(b)) prohibiting referrals to an entity that a physician has a financial relationship with (42 U.S.C. 1395nn). Public Health Law Section 238 of New York Law contains a similar, but broader, prohibition on referrals. Professional misconduct is committed when a physician directly or indirectly offers, gives, solicits or receives or agrees to receive any fee or other consideration for a referral of a patient in connection with performance of professional services. Sharing a fee with anyone other than a partner employee is misconduct.

OTHER DEFINITIONS OF MISCONDUCT

As noted above, there are various other specific areas of misconduct specified in the Education Law. Most of these are self evident, but bear mentioning. Failure to make documents available to a patient, improperly revealing patient information, practicing beyond the scope of competency, delegating responsibilities to an unqualified person, failure to inform a patient of the identities of caregivers involved in a procedure or surgery and performing services without authorization from the patient are all defined as misconduct. Violation of prohibitions on advertising (i.e. advertising which is not

in the public interest), failure to timely respond to a Department of Health inquiry, patient abandonment, patient harassment, abuse or intimidation, failure to maintain a proper record, guaranteeing satisfaction or a cure, ordering excessive tests or treatments, claiming to use or using secret methods, failure to wear an ID badge are also improper. Failure to post the names of principals of a group, performance of an autopsy without authority, failure to comply with an agreement made to practice in an underserved community, failure to complete forms for third-party payment are included as misconduct.

Additionally, there is an obligation to report physical abuse, mistreatment or neglect to persons receiving care or services in a residential health care facility. Refusal to provide care on the basis of race, creed, color, or national origin is misconduct. Practicing with a suspended license or failure to update the Department of Education with regard to information relevant to the license is also considered to be misconduct.

Sexual contact with a psychiatric patient, failure to provide an ophthalmology prescription to a patient are misconduct and finally, there is a catch-all for practicing medicine in a manner which evinces moral unfitness to practice. The most recent amendment to the Education Law adds failure to use barrier precautions and infection control practices and failure to advise the Department of health of adverse events such as patient death, unplanned transfer to hospital, unscheduled hospital admission or other life threatening events related to office-based surgery.

THE INTERVIEW

Despite the numerous categories of misconduct, the most common allegations of misconduct involve negligence and incompetence. This is most often encountered by professionals at the OPMC interview. Much attention has been given to issues of transparency in physician discipline recently. The most common discussion is over the disclosure of pending charges. It should be well noted that the interview process precedes the formal charge of misconduct and is in fact part of the investigation process. The call to an interview, therefore, would not be subject to such disclosure. When the OPMC determines that there may be some evidence of professional misconduct, the law requires OPMC to invite the targeted physician to come in to the OPMC offices for an interview and provides a means for the physician to present his or her side of the story before

charges are filed. In many cases this, in fact, avoids charges being filed.

The invitation to an interview with OPMC arrives by letter and is often the first notification that a physician has that an investigation is pending. The interview itself is the physician's only real opportunity to avoid having charges filed and therefore requires a great deal of preparation. OPMC strongly suggests that an attorney be retained to represent and prepare the physician for the interview with OPMC. Insurance policies with major insurers in New York often provide coverage for up to \$25,000 of legal expenses involved with representation in matters pending before the Office of Professional Medical Conduct.

When a letter inviting a professional to an interview with OPMC is received, the professional should contact his or her organization's risk manager, the appropriate insurance company to arrange for insurance coverage, and legal representation. The physician should not call OPMC until the matter has been discussed with an attorney. Often an attorney can obtain an adjournment of the interview in order to allow time for preparation but, the interview usually occurs within 30 to 40 days.

Preparation should include obtaining a copy of the quality assurance file and all records as well as reviewing these materials with the lawyer. Often it is not easy for the doctor to obtain these materials, however, it is in the best interest of the physician and the organization to review these items before the interview in order to properly prepare. There should be no impediments for risk managers to show the doctor records and quality assurance materials. If a patient was under the care of the doctor, then quality assurance materials become part of the personal file.

By the time the OPMC has invited the doctor to an interview, OPMC has generally reviewed the records, quality assurance materials and credentialing files has interviewed claimants and witnesses and reviewed the physician's history of prior incidents. OPMC does not provide access to this information.

The interview by OPMC is generally conducted by a medical conduct investigator and by a medical coordinator. The investigator, generally someone with a nursing background, is essentially the case manager of the investigation. The medical coordinator, a physician usually retired and usually Board Certified in the physician's specialty, runs the interview. During the interview the targeted physician must present the case

which requires complete knowledge of the factual and medical situation involved in the care, the applicable standards of practice in the area and the various alternatives that were or could have been considered at the time.

This means that the most important aspect of preparation is to spot the issues that OPMC will focus on. OPMC theories often rely on root cause analyses, actions by quality assurance committees, Department of Health statements of deficiencies or other sources. These are helpful for preparation but should not be relied upon solely, nor should the physician's own analytic powers complete the equation. The opinions of a lawyer, colleagues and independent experts are indispensable. Often, for a physician, it can be exceedingly difficult to approach colleagues under these circumstances. Since professional livelihood may be on the line, this is a time to swallow some pride and ask for as much help as possible.

Once documents have been compiled and the issues spotted and analyzed, there is no substitute for practice. A lawyer can provide a mock interview to simulate the questions and issues that the analysis has identified as problem areas. Rehearsal of answers is indispensable. There should be no surprises if preparation is complete.

Once at the interview, your lawyer should ask to see whatever documents the investigator is willing to present. OPMC will only do this immediately prior to the interview and it can provide a last minute chance for preparation.

The interview itself is often cordial and all efforts should be made to keep it professional. The medical coordinator and the investigator, after all, hold the physician's future in their hands. Every effort should be made to tackle the tough issues head on. Evasiveness is not helpful in this situation. The doctor should present the reasons for the medical judgments that were made during the course of care as well as the reasons that alternatives were rejected. A medical coordinator will certainly have questions and these should be answered, candidly.

Since OPMC's main concern is for public safety, it is helpful going into the interview having already taken remedial steps. Often the quality assurance committee or department head has already recommended some action. The fact that this action has been taken, as well

as anything that the doctor has learned is certainly helpful. Demonstration of concern, interest in learning from the event and improving care for patients outweigh the fact that such remediation can be perceived as an admission.

The investigators are interested in the specific determination of whether or not a standard of care was met or if the level of competence was appropriate. If, after the doctor's presentation, the investigators are convinced that the doctor is a competent and safe physician, it is unlikely that they will recommend charges of professional misconduct be filed.

OUTCOMES OF THE INTERVIEW

It often takes six months after the interview before OPMC announces what action it will take. There are essentially three outcomes of the interview process. The most desirable outcome is a letter from OPMC saying that they are closing their investigation. This is essentially an exoneration.

The OPMC often issues an administrative warning as a result of an investigation and interview where the medical error is found to be substantive, but does not rise to the level of misconduct. In this situation, the physician will be called back to OPMC offices to receive the administrative warning verbally. Often this means that they found the doctor negligent, but not grossly negligent, or not negligent on more than one occasion.

The physician will therefore be warned that if he is ever investigated again this matter can be reactivated and reinvestigated. In this regard, there is no statute of limitations on OPMC investigations and the OPMC can investigate any care that the doctor has ever rendered.

The third outcome of the interview process is a filing of formal charges. This leads to a hearing. The formal hearing is an administrative legal proceeding in which parties offer evidence and a decision is made by an administrative officer. A hearing panel reaches a determination on whether the charges have been proven. The hearing panel also recommends a penalty to be imposed.

PENALTIES FOR MISCONDUCT

The penalties prescribed by the Education Law range from censure and reprimand to suspension or revocation of license. Fines, mandated education, training and public service can also be imposed. Factors that affect the penalty recommendation include the seriousness

and nature of the misconduct, consistency with past recommendations for similar misconduct, patient harm or potential for harm, and mitigating factors such as the circumstances surrounding the incident.

Of course, any time after formal charges are issued, the matter can be settled and a consent agreement entered into. At this stage in the proceedings the negotiation skills of your lawyer are paramount. The doctor's efforts to explain his conduct during the interview can also be helpful at this stage. Mitigating circumstances and efforts made at remediation which were undertaken voluntarily can influence the board regarding severity of the penalty.

CONCLUSION

In 2008 Governor Paterson, in proposing legislation to enhance certain aspects of the physician disciplinary system, stated that "the physicians and other health care practitioners in New York State are among the best in the world. Nevertheless, there will always be a limited number of practitioners who fail to adhere to proper standards of care" (May 14, 2008 Press Release from the Governor's office). Indeed, health care practitioners adhere to the highest code of conduct and when questioned on their conduct must be fully prepared and must possess the tools to show the propriety of their conduct. Knowledge of the applicable law, thorough preparation and recognition of the issues are the best means to show this during an OPMC interview.

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By: Brian McCaffrey, Esq.

The need to obtain and correctly use medical records is not limited to the personal injury lawyer or the medical malpractice attorney. Recently, one of my colleagues, who is an estate lawyer successfully used medical records to prove that a transfer of real estate was invalid owing to the medical incompetence of one of the parties involved. In another example, a tax attorney used medical records to prove that his client lacked the mental capacity for fraud. And an entertainment lawyer successfully used medical records to disprove an insurance company's claim that his client was well aware of a disqualifying medical condition. No matter what area of law you practice, the time will come when the ability to obtain and use medical records will be crucial for the representation of your client.

Obtaining Medical Records

Once you have determined that a person's medical history and medical records may be useful for your case, the first thing you must do is acquire a complete copy of the records.

If the person whose records you are trying to obtain is your client, the process is fairly easy. The client, or the client's relatives, will be able to tell you which health care organizations (e.g., hospitals, doctors' offices, clinics, etc.) provided the treatment, and you can proceed to obtain those records in a relatively informal matter. If the records belong to an adversary or a non-party, however, you will need to rely on a court proceeding to obtain the information or obtain it through regular discovery in the lawsuit or pre-suit disclosure.

Regardless of the records you are trying to obtain, you must submit a form that complies with the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, patients and their legal and authorized representatives are entitled to review medical records pertaining to their own medical treatment. It is preferable to have clients attempt to obtain their own medical records because requests from patients do not set off all the bells and whistles at a health care organizations in the same way a letter from an attorney does. Once that bell is rung, there is a greater chance you will deal with excruciating delays or the possibility that defensive entries will be made in the records.

Health care organizations still ask for a HIPAA form even when patients themselves request information. Most bar associations, in cooperation with the medical community, have agreed upon standard HIPAA authorizations forms. For example, in New York State, the approved HIPAA form can be found in the Supreme Court section of www.courts.state.ny.us/attorneys/forms.shtml.

Every request for the release of medical records must follow certain guidelines:

- 1) If the request is from an attorney, it should be written on letterhead stationery or it must contain the complete name and address of the patient if the request is made directly by the patient.
- 2) The request should include the patient's signature authorizing release of the records to the name party. If the patient is deceased, incompetent or a minor, a legally appropriate individual, such as a parent, estate administrator or legal guardian should sign.
- 3) The authorizing signature should be validated with the stamp of a current notary or commissioner of deeds. Although the HIPAA form may not require such notarization, it is recommended in order to avoid having the record request rejected. Some states require that the notary have a raised seal on the document.
- 4) The request should include a special release form (compliant with any state and federal requirements) for patients being treated for psychiatric illness or alcohol or drug abuse or for any patient whose medical records document HIV- or AIDS-related information. The HIPAA form approved by the New York State Bar specifically has a checkoff for those items, and failure to initial them will result in the provider excluding them from the record.

Record requests are not limited to hospitals. In many jurisdictions, physician practices keep copies of medical records for as long as six years. Also, be sure to send an appropriate request for medical records to insurance carriers who paid for treatment.

An excellent resource for obtaining and evaluating medical records is an experienced nurse paralegal or

nurse attorney. There are also resource guides and websites available for the general practitioner that include:

ABA HEALTH LAW SECTION: www.abanet.org/health/home.html;

Borm Bruckmeier Publishing's online dictionary of medical abbreviations (also available in print or as a download) www.media4u.com/abb/medical_abbreviations.html;

JDMD's Medical abbreviations glossary : www.jdmd.com/glossary/jdmd_glossary.pdf;

MediLexicon's online dictionary of medical and hospital abbreviations and terminology: www.pharma-lexicon.com;

TRICARE's web page on HIPAA and the military: www.tricare.mil/hippa

U.S. Department of Health and Human services' web page on HIPAA: www.hhs.gov/ocr/hippa

Processing Requests & Responses

Below are recommendations that will help you keep track of the medical record requests and responses you send and receive.

- 1) Set up a folder to store a copy of your request for records from each health care provider and a copy of the previously executed HIPAA form. Organizing your documentation in this way will make life a lot easier when responses come back. Many responses may include other medical records from other medical providers.
- 2) Review records for completeness. Pay particular attention to the presence or absence of certain items that may be relevant to the case in question such as a typed operative report or a pertinent laboratory report. If anything essential is missing, particularly from hospital charts, contact the medical provider. It may be possible that some items have been misplaced and or not yet filed. In such cases, it is important to determine if the provider has electronic logs of tests performed or if particular medical departments have other systems for documenting procedures and results.
- 3) While this is not an all-inclusive list, a typical medical record might have the following components:
 - a) History and physical
 - b) Physician's progress notes
 - c) Physician's order sheets

- d) Nurse's notes (general and special care unit) and nursing care plans
- e) Graphic and flow sheets (pulse, temperature, respiration [PTR])
- f) Intake and output [I&O]
- g) Activities of daily living [ADL]
- h) Medication records
- i) Laboratory and pathology reports
- j) Transfusion records
- k) X-ray reports
- l) Operative or procedure reports
- m) Consultation reports
- n) Emergency department records
- o) Records for special health care disciplines (e.g., physical therapy)
- p) Consent forms
- q) Discharge summaries
- r) Autopsy reports
- s) Insurance claims, Explanation of Benefits (EOBs) and denials

- 4) Since many health care organizations do not consider certain clinical or miscellaneous documents to be part of the medical record, you must specifically ask for them if they are important to your case. The clinical documents might include the following:

- a) *Cardiac catheter laboratory technician records.*
- b) *Cardiothoracic surgery (bypass) pumps records*
- c) *Dialysis flow sheets.*
- d) *Epidemiology logs.*
- e) *Fetal monitoring strips.*
- f) *Hospital bylaws.*
- g) *implantable devices.*
- h) *Incident/Occurrence report forms.*

Incident reports often contain details regarding the "who, what, when, and where" of an occurrence and are a valuable source of information, particularly if the legal issues related to professional or general liability or safety issues.

- i) *Needle and sponge count.*

Sponge counts are performed by the scrub and circulating nurses in the OR or procedure suites. It is important to review the count when a case involves a retained foreign body.

- j) *Nursing administration's report.*

This report contains information on patients who are very sick or who have special problems. Information from the nursing administration's report sheet may supplement occurrence reports or the information contained in the patient's medical record.

- k) *Nursing assignment records.*

This information is useful in supplementing nurses' notes or progress notes to identify the nurses caring for a patient on a particular day.

l) *On-call schedules.*

m) *Operating room circulation slips.*

These forms contain the names of individuals present during a surgical procedure and sometimes reveal people who should not be present.

n) *Other departmental records.*

Other departments might include social services, occupational therapy, physical therapy, pharmacy, and anesthesia.

o) *Patient data logs.*

Some clinical areas maintain logs or computerized databases that include the names of all individuals that they have treated in the operating room, delivery room, emergency department, outpatient clinics, radiology/nuclear medicine department, cardiac catheterization department, laboratory, blood bank, and donor bank.

p) *Private duty nursing logs.*

These logs can help identify private duty nurses who have cared for the patient or may contain information on an interview related to patient care.. They are often missed by the hospital when they do their investigation.

q) *Psychiatry flow sheets.*

Most psychiatric units use some form of flow sheets to monitor patient activity throughout the day. Patients who are at risk for suicide or elopement are monitored more frequently by staff to assess their safety and verify their presence on the unit. Usually staff performs these patient assessments every 15 minutes to once an hour. These flow sheets may not be kept for a long period of time; therefore, it is important that they be requested immediately after a recent hospitalization.

- 5) Health care organizations also maintain a variety of other miscellaneous documents that are not directly related to the clinical treatment of the patient such as:

a) *Biological Engineering or Biomedicine records.*

The Biological Engineering or Biomedicine department maintains records of maintenance and equipment repairs throughout the hospital, as well as work orders and maintenance request logs. Such records may be helpful when investigating an injury that involves equipment-related occurrences.

b) *Contracts and agreements.*

Health care organizations usually maintain many different contracts and agreements with outside parties, vendors, and groups such as physician groups, HMOs, and other health care organizations. These documents often contain a helpful "hold harmless" clause which can be useful if you want someone's carrier to assume your defense or if you want to explain to a jury why apparent antagonists are surprisingly cooperative.

c) *Crisis Management or Disaster records and reports.*

These documents detail extraordinary events such as fires and natural disasters and may be useful if they relate to your case.

d) *Medical Staff bylaws.*

These generally outline the duties and responsibilities of the medical staff and the requirements for maintaining medical staff privileges.

e) *Patient bills.*

f) *Physician credentialing files.*

g) *Quality/Performance Improvement Committee minutes.*

h) *Root cause analysis.*

The Joint Commission (formerly known as Joint Commission on Accreditation of Health Care Organizations or JCAHO) requires all accredited health care organizations to identify, report, and respond to serious patient occurrences. Such occurrences are known as "adverse outcomes" or "sentinel events." All health care organizations must complete a root cause analysis for reportable events and root cause analysis findings may be a good source of information for the attorney. Check local laws, however, to determine if it is permissible to obtain copies of these documents. Some institutions attempt to identify them as privileged and protected "quality improvement" documents rather than "incident reports" in order to prevent attorneys from gaining access to them. Often an institution arguably waives such a privilege by giving the document wider distribution than should be permitted under their statute. This should be kept in mind when interviewing or deposing a medical provider to determine what documents they have reviewed.

i) *Training/assessment files.*

These files are generally kept in the Nursing Education or Safety divisions or in specific clinical departments and may contain details on educational programs or the names of individuals

who successfully completed training as well as information on the procedures they are credentialed to perform.

Reviewing the Records

When you have got what are believed to be complete copies of the medical records, review the records in their entirety. At some point during your review, you may need to perform medical research on unfamiliar subjects or contact appropriate medical specialists or experts for assistance. Review the records from your own legal perspective as well as your adversary's. Identify any people involved in occurrences and make a list of questions to ask each person who might be interviewed. Scrutinize every word describing the details of occurrences and any notes written in the margins, inflammatory or angry language or discrepancies. At some point during litigation you may be entitled to look at original documents from medical records and it is important to note any alterations or questionable entries, missing pages, scratched out entries, notes that have been written over or the use of different-colored inks and correction fluid. Every attorney has their own organizational system and preparation process; however, the following methods have been recommended by professional medical review investigators and are useful when an attorney or nurse attorney/nurse paralegal is reviewing medical records.

- Photocopy records so notes can be written on the copy.
- Use paper clips or dividers to separate the records.
- Use self-stick notes to make comments on individual pages - do not write on the record itself.
- Number the progress note pages on the copy if that has not already been done.
- Pull the photocopied chart apart and put in into organized sections so that different sections can be easily cross-referenced (such as doctors orders, progress notes, laboratory reports, etc.).
- Mark pages containing important names, dates or any other information that might be referred to during interviews or depositions.
- Create a time line or flowchart of events.

Reorganizing the Records

After reviewing relevant medical records, make sure to organize the records before proceeding to depositions. With respect to hospital records, organize each hospitalization individually by dates of admission. For

multiple admissions to different facilities, organize them by facility. Use a binder and medical records tabs. When you are dealing with records from a physician's office, organize them in a fashion similar to hospital records, if possible. Look for new patient history or initial screening forms that should be filled out for each new patient. Separate progress notes, correspondence and medical record excerpts from other providers or billers. Often there may be hints that something went wrong with the production of the records, requiring you to look at the originals. Look in particular for:

- notes written on the same date but with different ink or different slant to the handwriting
- changes or differences in the alignment of the notes
- writing that is crowded around other entries
- words that are written over, under, or around original entries
- billing entries that conflict with the treatment records
- records that do not make sense chronologically

Using the Records

Prepare an outline for what you want to do with the medical records. In the case of a medical malpractice or personal injury lawsuit, insist that the original records be provided at the actual deposition. Most jurisdictions only provide for the provisions of copies prior to the deposition. Alterations to the records are not readily obvious in photocopies, so this will allow you to compare your copies to the originals. When conducting depositions of medical providers, question them as to whether they believe the records are complete and accurate. Also question when they reviewed the medical records in preparation for the deposition as this often leads to a new line for investigation or perhaps a waiver of privilege. Don't forget to ask medical practitioners whether they maintain copies of the medical records. After you have conducted depositions and are ready to go to trial, you now must ensure that you can get these medical records admitted as evidence. Each jurisdiction has its own particular rules, but generally you must meet the following requirements to get a medical record or a portion of a medical record admitted:

- The record must be an original copy or, if not, a certified copy of the original.
- The record must be a complete and accurate copy and must be certified as such.

- The use of the record must not be barred by privilege—in other words, a waiver of this privilege should have already been obtained.

Be sure to serve the person who is responsible to maintain the records with a subpoena duces tecum. As a rule, courts do not permit attorneys to simply walk into Court with their own set of medical records for admission as evidence. On occasion this might be allowed as a matter of courtesy but cannot be relied on even if you and your adversary agree as the judge may not allow it. In the state of New York, a subpoena served on a hospital must be so-ordered by the court. The requested records will be returned to court with the hospital's certification indicating that the records are admissible according to New York State rules. As a matter of practice, it is best to provide the appropriate certification forms when serving the subpoena to enable the records keepers to complete them in addition to their own particular institutional forms. It is surprising how many hospital certifications do not comply with the statutory rules for certification of admissibility of medical records. Also keep in mind that many jurisdictions distinguish between the admissibility of medical records produced by a hospital and those produced by a private medical provider's office.

Many jurisdictions require the custodian of the records at a doctor's office to testify that the records are kept in the ordinary course of business in order to admit them under the business record exception rule. Again, this particular rule is often waived by stipulation of counsel when they agree to the admission of medical records from a doctor's office in which case the subpoena will not require the actual record keeper to appear. This professional courtesy for doctors' offices is generally encouraged by trial judges.

Most jurisdictions require the following foundation for the admissibility of hospital records:

- the record must be a regular form of entry kept in the regular course of business of a hospital
- the entries made within a particular record must be made in the usual course of business
- the entries must be made close in time to the fact that it purports to record. Surprisingly, most hospital certifications are deficient in some respect

Objections may be made to particular parts of a hospital record if the entries are not relevant to diagnosis and treatment. Therefore, if these entries are relevant to

treatment, arguments can be made that the following portions of hospital records are admissible:

- dates of admission and discharge
- symptoms, past medical history and presenting complaints
- diagnosis and prognosis
- treatment, history if relevant to the diagnosis and treatment
- conclusions by expert physicians (e.g., a doctor's statement that a patient is malingering)
- nurse's notes and progress notes
- laboratory and X-ray reports
- entries regarding observations or admissions of alcohol consumption.

Opinions from those other than experts that are not based on observation are not admissible and neither are letters or data obtained from third parties.

Depending on the jurisdiction, it may be necessary to determine whether or not a medical record is or isn't considered hearsay or whether a foundation must be established for hearsay exceptions. In most jurisdictions, a statement made for the purpose of getting medical treatment is considered an exception to hearsay. In Federal court under rule 803(4) and 803(3), a statement made to persons other than those immediately able to render medical assistance will be admissible only if it was made for the purposes of obtaining medical diagnosis and treatment. For example, in a case where a statement was made by a child to police officers as to how her mother was injured while the mother was unconscious and required medical treatment, the statement was considered admissible under rule 803(4) exception. Likewise an entry in the patient's medical history describing a statement by a patient or an authorized representative (parent, guardian, health care proxy, etc.) consenting to medical treatment on the patient's behalf is considered admissible despite the rule against hearsay.

In situations where nurses' notes or other medical records contain observations of the patient mental status such as level of consciousness, evidence of intoxication or statements made against the interest of the patient, many jurisdictions require that the author of such notes be available to testify in court regarding the circumstances surrounding the entry. When it is intended to cite such entries at trial, the author may need to be identified and subpoenaed to testify.

Many hospitals may indicate that x-rays, MRIs, CAT scans and other diagnostic tests and films are not considered part of the medical record. These items often have specific statutory rules for admission, Therefore, it is necessary to check local rules for the actual foundation requiring such materials to be admitted. For example, local rules may require that x-ray or diagnostic films have the name of the patient, the doctor who performed the study, the facility where it was performed and the date on the actual film. Other local or Federal rules may permit such films and diagnostic tests to be admitted as evidence without bringing in the actual person who took the films or without certification, provided a copy of your intent to admit such films at trial is served upon your adversary to permit them the statutory time to examine said films in your office.

Conclusion

Below are some final caveats with respect to medical records:

Be aware of the “subject to connection” admonition, which many judges impose on medical records that you think have been admitted at trial. Despite your diligent efforts, you may find that many medical documents and many impressive narrative reports and diagnostic tools will not go to the jury because you have failed to introduce the proper testimony by a competent medical expert to explain them to a jury.

When your case ends and the time for appeals has expired, send letters to the providers revoking the HIPAA release form or other medical authorizations you provided on behalf of your client. Your jurisdiction probably has rules that requires you to retain these records for a certain time period after the case has been closed, settled or otherwise brought to an end. When the mandatory period for you to retain these records has passed, be sure to properly dispose of these records by shredding or burning them. There are services that provide a HIPPA compliant certificate of destruction for medical records.

Ultimately, the use of medical records in developing a case during discovery and at trial can be time-consuming and expensive, but may be worth more than the time and expense in the end.

Brian McCaffrey is a trial attorney whose practice focuses on defending medical institutions and medical professionals in: Medicare/Medicaid Fraud; Medical Malpractice; and Employment cases. He is a founding member of Leffler Marcus & McCaffrey LLC in New York City and may be reached at bmccaffrey@lmmlawfirm.com.



Upcoming Educational Program

Annual Conference, Friday, June 12th, 2009

“Risk Financing Tools for New York Healthcare Providers Conquering the Challenging Economic Times”

AHRMNY’s Annual Conference will focus on the financial health of the New York healthcare industry. The program will analyze how local healthcare institutions are weathering the storm and advice on best practices to survive the current economic environment.

The conferences will be held in the Swiss Re Conference Center at St. Vincent Medical Center from 8:00am – 3:30pm

Please log onto www.ahrmny.com to obtain a copy of the full detailed brochure and registration instructions.

WE WANT TO HEAR FROM YOU!

We are asking our readers to submit articles to appear in the Summer and Fall edition of *AHRMNY NEWS*. Submission of articles that focus on safe patient care practices, safe working environments, legal and financial updates in the health care arena are some of the topics we seek.

AHRMNY NEWS is published four times a year with a distribution of 200-300 copies per quarter.

Please forward any ideas or submissions for publication in the *AHRMNY NEWS* to “Editors”, via email with attachments to: CGulinello@lmc.com

HEALTHCARE RISK MANAGEMENT WEEK JUNE 15-19, 2009



The theme for 2009’s Healthcare Risk Management Week, June 15-19, is “Thinking Safety, Earning Trust.”

This is an opportunity for AHRMNY members to promote safe and trusted healthcare to their organizations, communities and clients.

See the national chapter’s website at www.ashrm.org for celebratory ideas and commemorative gifts.

RISKY BUSINESS

“When Common Sense is Uncommon”

By: Pamela Monastero, MBA, CASHRM
Linda Rowett, RN, BSN, Risk Management Consultant

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Newsletter, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. The column is anonymous and we encourage our members to submit their experiences which may be e-mailed to Pamela.monastero@nychhc.org or mailed to AHRMNY, P.O. Box on the RISKY BUSINESS form which can be found on our website at AHRMNY.org. The form permits confidentiality.

This edition of our column is devoted to violence in the workplace, particularly in hospitals and other healthcare settings. Television shows frequently depict violence in healthcare settings—especially in hospital emergency rooms. The perpetrators can include visitors, staff or even other patients. Such events are highly unpredictable. Ensuring a safe environment in the healthcare setting is complicated, given the need to maintain an open/public environment while protecting a vulnerable patient population and ensuring that barriers to entry for those seeking healthcare remain low. Policies and security tactics vary from facility to facility and from region to region. Some healthcare entities may have strict policies, including the use of metal detectors, wands and bag checks, fingerprinting, biomedical recognition (e.g. optical imaging), etc. Yet others may view such methods as barriers to entry for the underprivileged (e.g. undocumented immigrants) who seek care at their facilities. When addressing violence prevention in the workplace, there is no clear “one size fits all” solution.

Currently, Federal regulations do not exist mandating the use of metal detectors/wands/bag checks or other methods (such as those used for airport security) to aid in preventing persons from entering a healthcare facility with guns, knives, box cutters and other dangerous weapons (e.g. explosives). Such a mandate would no doubt be expensive for already financially-strapped facilities to comply with; however, in terms of patient safety and risk avoidance, this would be a proactive step towards protecting a vulnerable patient population, as well as other innocent visitors and staff.

The United States Department of Labor’s Occupational Safety & Health Administration (OSHA) website (<http://osha.gov/SLTC/workplaceviolence/index.html>) is a useful resource for workplace violence and offers sample policies and tools for healthcare (and other) entities. The OSHA website is rich in statistics on workplace violence and offers countless links on *Hazard Awareness*, *Federal Register* (links to legal references), *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* and a *Hospital e-tool* (e.g. for Emergency Departments as well as other areas of hospitals). The OSHA “Survey of Occupational Injuries and Illnesses” (2000) indicates that health care and social service workers face an increased risk of work-related assaults stemming from several factors. These include:

- The prevalence of handguns and other weapons among patients, their families or friends;
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals;
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others);
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets;
- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly;
- The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members;
- Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients;
- Isolated work with clients during examinations or treatment;

- Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings);
- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior; and poorly lit parking areas

What is workplace violence?

Violent acts (including physical assaults and threats of assault) directed at persons at work or on duty.”

[National Institute for Occupational Safety and Health (NIOSH)]

- Any form of violence in the workplace, including:
 - verbal assault
 - threat of assault or intent to harm
 - physical assault
 - use of weaponry including firearms, sharp objects, chemical weapons
 - terrorism

Recognizing violence

- Uncontrolled behavior
- Threat of harm
- Actual harm caused by physical force
- Irrational reaction to stress, frustration, jealousy, worry
- Use of weaponry to overpower or create an outcome related to false empowerment

Contributing factors

- Anger, frustration, disappointment
- Stress, worry, loss
- Inability to cope
- Inability to respond to a change or stressor
- Insecurity/feeling powerless
- Mental illness or sudden change in mental status
- Insanity
- Threat of or actual physical force

Situations leading to agitation and potential for violence

- Arguments/differing opinions leading to verbal threat or physical force
 - Patients
 - Employees
 - Family members
 - Visitors
- Impaired mental status/disorientation
 - Dementia, Alzheimer’s Disease, mental illness
 - Anesthesia, medications, illicit drugs, alcohol, metabolic disorders
- Poor coping and communication skills
 - Difficulty communicating in a productive manner
 - Unable to express needs or feelings
 - Insecurity and feelings of inferiority
 - “Loose cannon”

Physical warning signs

- Facial expression
 - Grimacing
 - Furrowed brow
 - Clenched jaw
- Speech
 - Angry tone
 - Loud voice
 - Rapid or forceful
 - Profanity

- Body language
 - Agitation
 - Pointing fingers
 - Lunging or leaning forward
 - Shifting stance
 - Quick, sudden movements
 - Crossed arms
 - Raised arms
 - Clenched fists

Preventive Measures

- Use metal detectors to screen all persons who enter a facility
- Use surveillance cameras or post security staff where needed
- Institute practices such as sign-in sheets for all visitors including name, destination and reason for visit
- Enforce visiting hours
- Wear & inspect employee identification badges
- Use buddy systems to travel to isolated areas or call for Security escort
- Screen patients and flag charts for history of aggressive or combative behavior
- Create and use “safe rooms” when tension escalates
- Avoid openly carrying sharp objects that can easily be grabbed and used as weapons– scissors, keys, pens
- Remove objects from environment that could be used as weapons (heavy or sharp objects, glass, etc.)
- Keep entryways, hallways and parking lots brightly lit
- Lock all unused doors /windows to prevent unauthorized access to the premises
- Restrict or closely monitor visitors who are known to be disruptive
- Any suspicious individuals or activities should be reported to Security immediately
- For difficulty de-escalating a hostile situation, seek help immediately

Safety Strategies

- Recognize the potential for violence
 - Be aware at all times
 - observe surroundings and activities/interactions
 - Pay attention to heated interactions or angry behavior
 - Notify appropriate department heads and supervisors
- Be proactive – report unsafe conditions
 - unsecured entry points (open doors, open/broken windows)
 - poorly lit areas (hallways, parking lot, restrooms, etc.)
 - suspicious visitors
 - unusual behavior
 - potential hiding places
- Immediately replace/repair broken locks, burnt-out light bulbs and broken windows
- For any violent situation already underway, leave area and summon help immediately
- Require staff to privately and discreetly report personal orders of protection or any threats of violence to supervisor and Security Department
- Discourage and prevent personal/family disputes on hospital premises through policy
- Use self-defense in the event of hostile interaction involving verbal or physical threat of harm
 - avoid physical contact of any kind
 - maintain safe distance
 - back away while staying focused on aggressor
 - get to a place where assistance is available, if possible
 - call for help
- Plan in advance when patients/employees/visitors are known to be disruptive
 - Be prepared to handle conflict if and when it arises
 - Avoid becoming trapped – position self near door and have someone else present to seek help if necessary
 - Develop and use safety codes to alert other staff
 - Ask Security to escort disruptive visitors off the premises
 - Make supervisor and Human Resources aware of disruptive employees

- Assign staff to:
 - Secure patient care units, treatment areas and doors to patient rooms
 - Prevent entry by outsiders
 - Direct individuals to safety
- Post phone numbers for Security Department, Crisis Intervention Team and local law enforcement on all units and in all departments that are clearly visible and near all telephones
- Document hostile or violent behavior on incident reports for improvement purposes
 - Use experiences to establish and improve prevention strategies
- Conduct drills, simulate events, role play, etc.
- Share ideas for improving safety with leadership – encourage input from all

COMMON SENSE TIPS FOR STAFF:

Tip: Review the Occupational Safety & Health Administration (OSHA) website for tips on:

- elements of a violence prevention program
- management commitment and employee involvement
- worksite analysis including:
 - screening surveys
 - conducting a workplace security analysis
- hazard prevention and controls including:
 - workplace adaptations to minimize risk
 - administrative and work practice controls to minimize risk, employer responses to incidents of violence
 - safety and health training
 - record keeping and elements of program evaluation
 - sources for assistance
 - supportive references.

Be certain to review the Appendix A Workplace Violence Program Checklists and Appendix B Violence Incident Report Forms on the OSHA website.

Reason: Healthcare settings are public places and are unpredictable and vulnerable environments. These environments are filled with emotion, tragedy and sometimes with dysfunction and chaos. Pre-planning for violence and the implementation of proactive measures, such as violence prevention policies and procedures and improving security at entryways by thoroughly screening visitors and employees, serve to minimize the risks and consequences of violence.

Tools & Resources:

www.OSHA.gov

<http://www.crisisprevention.com/program/nci.html>

Change to New York Insurance Law: New York Insurers Face Tougher Times Following Passage of Law Eroding Late Notice Defense and Providing for Direct Action Against Insurers

By: Stephen M. Marcellino, Adam R. Bialek, Jennifer Alampi

After a failed attempt in 2007 to change the law in New York regarding “late notice” given to insurers, New York Governor, David A. Paterson, finally signed a bill passed by the New York State Legislature effectively eroding the late-notice defense available to insurers under liability policies covering personal injury and property damage. The law, signed on July 2, 2008, further allows claimants to bring direct actions against insurers who have disclaimed coverage due to late notice.

The new law, effective 180 days from signing (i.e., January 17, 2009), will impact policies issued on or subsequent to the effective date.

Existing Law

Historically, in New York, insurers have been able to deny coverage where an insured’s notice of an occurrence was not timely provided to the insurer without having to demonstrate that the insurer suffered any prejudice by the delay. The insured was required to demonstrate that it was not reasonably possible to have given such notice within the prescribed time, and that notice was provided as soon as was reasonably practicable. Since the insurer was not required to show any prejudice as a result of the late notice in order to disclaim coverage, insureds were required to be extremely vigilant in notifying their insurers when circumstances required that notice be given¹.

This ability that insurers had to disclaim coverage, without proving prejudice, often led to insureds defending themselves without coverage they had purchased, and claimants not having the proverbial deep pocket from which to seek compensation. A claimant could not bring an action directly against the insurer of the third party insured for a declaration that the policy covers the claimed loss until after a verdict and judgment were rendered against an insured in the underlying litigation.² If a judgment against the insured remained unsatisfied for thirty days or more a claimant could file a direct action against an insurer pursuant to Insurance Law

§ 3420. However, neither the common law nor Insurance Law § 3420 authorized a direct action against the insurer, including a declaratory judgment action, before the claimant obtained such a judgment. The new law seeks to protect individuals who suffer personal injuries and property damage by eliminating these longstanding principles, and allowing for direct actions against an insurer earlier.

Legislation & Analysis

For approximately one year, the New York State Legislature unsuccessfully attempted to pass a bill accomplishing the above-noted changes. After receiving instruction from New York’s prior Governor about issues that needed to be addressed, the Legislature produced a version of the bill that New York’s Executive leadership believed accomplishes the goal without causing undue hardship on the insurers.

The purpose of the law is to:

(1) prohibit certain liability insurers from denying coverage based on late notice, unless the insurer suffers prejudice as a result of the delayed notice, which is defined as an impairment to the insurer’s ability to investigate or defend a claim; and

(2) permit a claimant in a personal injury or wrongful death case to commence a declaratory judgment action against the defendant’s insurer, in limited circumstances, to challenge the insurer’s denial of coverage based on late notice.

The Changes

The passage of this new law brings New York into line with the majority rule throughout the United States and includes the following changes:

Section 1 of the legislation amends New York’s Civil Practice Law and Rules (“CPLR”) § 3001 to permit a claimant in a personal injury or wrongful death case to file an action directly against the insurer of a defendant to the lawsuit, as provided under Insurance Law § 3420(a)(6).

Section 2 of the legislation amends Insurance Law § 3420(a) to require occurrence based liability policies for bodily injury or property damage, issued or delivered in New York, to contain a provision that:

(1) failure to give notice as prescribed by the policy will not invalidate a claim made by the insured, injured person or any other claimant unless the late notice has prejudiced the insurer; and

(2) with respect to a personal injury or wrongful death claim, if the insurer disclaims liability or denies coverage based on a failure to provide timely notice, then the injured person or other claimant may maintain an action directly against an insurer, on the question of late notice, unless the insured or the insurer, within sixty days of the disclaimer, initiates an action under the policy, naming the injured person or other claimant as a party to the action.

Section 2 in effect, however, exempts claims-made policies from the new notice rules, maintaining the integrity of a “claims made” insurance policy.

Section 4 of the legislation amends Insurance Law § 3420(c) to establish the burdens of an insured or an insurer in three possible scenarios:

(1) if notice is provided to the insurer within two years of the time required under the policy, then the burden falls on the insurer to demonstrate that it was prejudiced by the late notice;

(2) if notice is provided to the insurer more than two years after the time required under the policy, then the burden falls on the insured, injured person or other claimant to show that the insurer is not prejudiced; and,

(3) if notice is provided to the insurer after the insured’s liability is determined, or after the insured has settled the case, then there

would be an irrefutable presumption of prejudice because the insurer’s rights would be impaired by the liability determination or settlement.

Section 4 of the legislation also provides that the insurer’s rights will not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim. Materiality, however, is not defined, which leaves open an area that may be subject to further refinement or court review.

Section 5 of the legislation amends Insurance Law §3420(d) to establish a process for a claimant to receive confirmation from an insurer that the insured had an insurance policy in effect on the alleged occurrence date, and the limits of such policy. This section of the legislation also establishes a protocol to be followed if insufficient information is provided to the insurer and such confirmation is not possible. Specifically, this section was amended to provide:

(B) Upon an insurer’s receipt of a written request by an injured person who has filed a claim or by another claimant, an insurer shall, within sixty days of receipt of the written request: (i) confirm to the injured person or other claimant in writing whether the insured had a liability insurance policy of the type specified in subparagraph (A) of this paragraph in effect with the insurer on the date of the alleged occurrence; and (ii) specify the liability insurance limits of the coverage provided under the policy.

(C) If the injured person or other claimant fails to provide sufficient identifying information to allow the insurer, in the exercise of reasonable diligence, to identify a liability insurance policy that may be relevant to the claim, the insurer shall within forty-five days of receipt of the written request, so advise the injured person or other claimant in writing and identify for the injured person or other claimant the additional information needed. Within forty-five days of receipt of the additional information, the insurer shall provide the information required under subparagraph (B) of this paragraph.

Section 7 of the legislation provides that failure to promptly disclose coverage pursuant to Insurance Law § 3420(d) may constitute unfair claims settlement practices.

On November 18, 2008, in Circular Letter No. 26 (2008), the New York State Insurance department reminded all property and casualty insurers that policy forms needed to be drafted or revised to reflect the new language of the law.

Commentary

This bill was not the first attempt to change “late notice” in New York. In fact, a similar bill was passed in 2007 but vetoed by then Governor Eliot Spitzer. Governor Spitzer vetoed the bill, finding a serious dispute existed concerning the impact of the changes and noting that many insurers and business groups strenuously objected to it because of concerns that it would increase litigation costs and insurance premiums.

Governor Spitzer further found that there had not been sufficient time for the legislators to consider the bill. He instructed his staff and the Superintendent of Insurance to work with both Houses of the Legislature, the insurance industry, business groups, consumer advocates, the trial bar and the Office of Court Administration to investigate the impact of the changes on injured parties, insurance rates, and court caseloads. While he found that the bill’s dual goals – streamlining litigation and prohibiting the denial of coverage for mere technicalities – were sound, he hoped to enact a new bill that accomplished these important goals in a manner that protected the interests of claimants, policyholders, and insurers alike.

The new legislation, signed by Governor Paterson provides for sweeping changes relative to late-notice denials and the right to bring direct actions against insurers. However, there is no definition of “material prejudice” in either this legislation or in the Insurance Law, and this determination will likely be decided on a case-by-case basis.

The impact of the legislation remains to be seen. The new legislation reflects a marked departure from longstanding precedent, and, for the first time, imposes an affirmative burden on the insurer to prove prejudice to disclaim coverage on the ground of late notice. It will likely spawn new litigation against insurers and require

insurance carriers to alter well established practices. The legislation is designed to protect claimants from judgment proof insureds and to protect insureds from having to fund litigation and liability findings when they fail to provide timely notice of an occurrence to their insurers. The impact of this new legislation on insureds and risk management remains to be seen.

Risk Managers, who may be relieved by the law’s allowance of late noticed claims, should not be duped into lax reporting. It is still essential for risk managers to timely report claims to protect the policy and to allow for an immediate investigation to be performed and for defense counsel to be retained. Moreover, late reporting is not likely to be viewed kindly by underwriters when policies are up for renewal or quote. In the event an insurer does disclaim, an insured would not want to have a claimant intercede between its affairs with its insurer.

It should be noted that this legislation is limited to personal injury and property damage policies and will impact such policies issued on or subsequent to January 17, 2009. Although there is no reference to other types of insurance policies, such as professional liability policies, it is anticipated that policyholders will make efforts to stretch the bounds of the new law to other insurance vehicles. The Courts will be required to address issues such as “materiality” or material prejudice. In any event, the insurers will need to alter their approach to claims and claims handling or risk exposure themselves, and risk managers need to be aware of the developments to maximize their leverage when negotiating with insurers.

¹ See *Security Mutual Ins. Co. of NY v. Acker – Fitzsimons Corp.*, 31 N.Y.2d 436, 440-441 (1972); *Great Canal Realty Corp. v. Seneca Ins. Co., Inc.*, 5 N.Y.3d 742, 743 (2005).

¹ See *Lang v. Hanover Insurance Co.*, 3 N.Y.3d 350, 787 N.Y.S.2d 211, 820 N.E.2d 855 (2004).

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AHRMNY NEWS, the official newsletter of the Association for Healthcare Risk Management of New York, inc. is published four times a year.

AHRMNY Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This newsletter will contain articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as notices of improvement and other relevant information of interest to risk managers. The articles are usually written by *AHRMNY* members, so the newsletter serves as an opportunity for members to showcase their writing talents.

For the official *AHRMNY* Author Guidelines visit our website <http://www.ahrmny.com>

Please forward any ideas or submissions for publication in the *AHRMNY NEWS* to “**Editors**”, via email with attachments to: CGulinello@lmcmc.com

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Reminder

Maximum article length 3,500 words

Photo requirements (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

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