

# THE SCOPE

**MEDICAL EDITION**

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**ISSUE 19**

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“Snowbird Patients”

**Risk Management Tip:**  
The Proper Use of  
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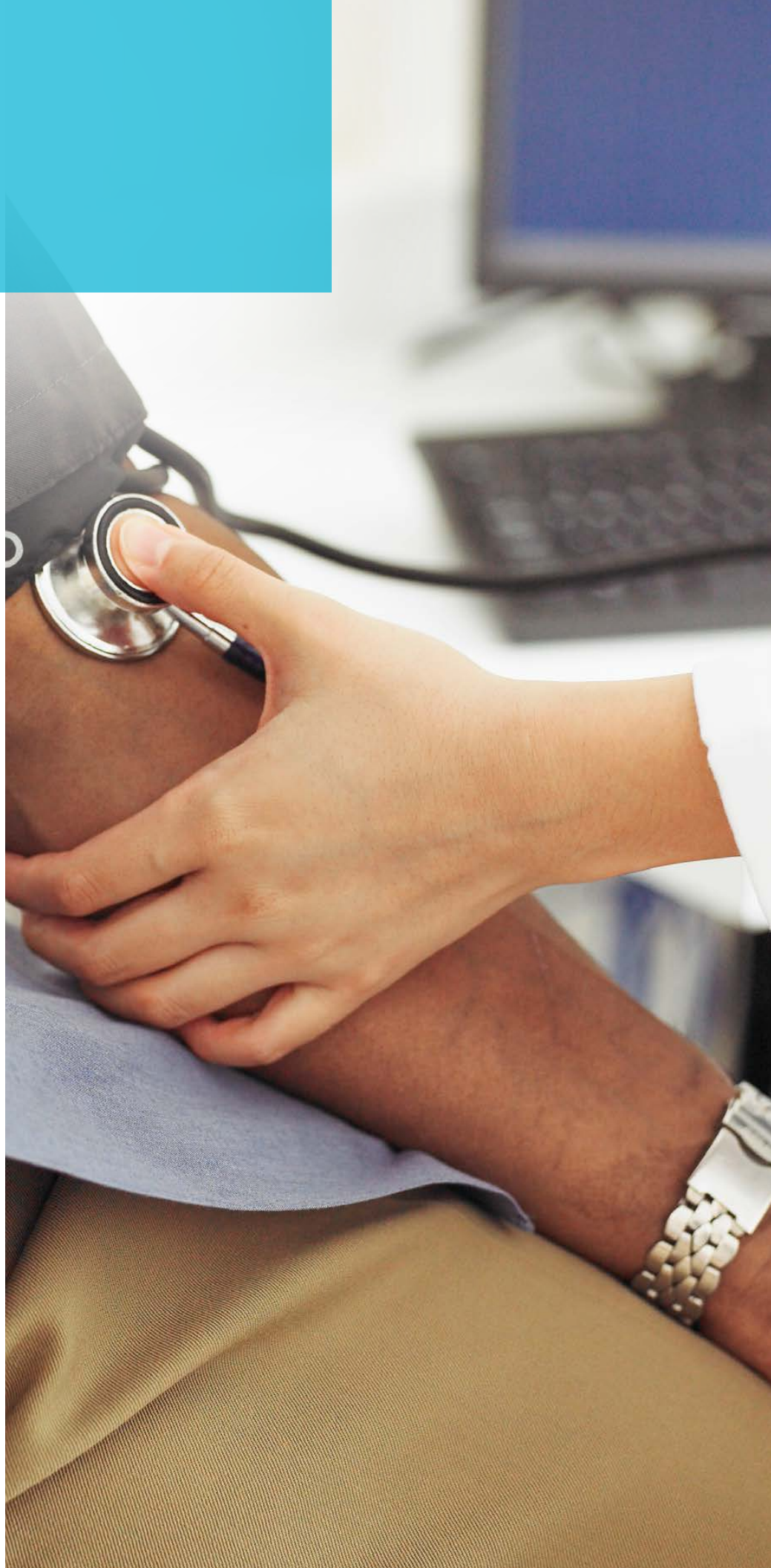
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## EXECUTIVE MESSAGE



# Dear Policyholders,

Through claims data and constant communication with our insureds, MLMIC Risk Management is able to identify and address loss drivers and emerging concerns. This is not, however, the extent of our diligence on your behalf. The healthcare Risk Management community is vast, dedicated, and generous in sharing the lessons learned from helping to address the many challenges faced by providers. This collaboration is on full display each autumn with the annual ASHRM (American Society for Healthcare Risk Management) conference, which draws hundreds of healthcare risk professionals together for education, networking, and the benefit of shared experience on a national level. Not surprising, this year's aggressive education docket placed a focus on the leveraging of data and the safe use of AI technology. There was also a fascinating discussion addressing the management of mental health patients in the ED, a data driven dive into weekend and time of year impacts on poor patient outcomes, and so much more.

Because we know that New York State is its own animal, MLMIC is deeply involved in AHRMNY (Association of Healthcare Risk Management of New York), which holds their Upstate NY conference each fall. This gathering of healthcare risk managers, facility administrators, attorneys, and agents addresses many of the same risk considerations but is able to overlay the forces that are uniquely New York. Along with coverage of loss drivers and developments in the delivery of medical care, the event's discussions and education explored New York specific medical-legal issues, the ever-developing case law, and pending legislation.

This issue of *The Scope* features an article that explores the "Snowbird" phenomenon, an annual patient migration that affects the delivery of healthcare over much of the country and also raises considerations specific to New York. The topic exemplifies the narrowing of national issues in risk to New York applications and is one that will likely be relevant to your practice or facility. I hope that you find this and the entire issue to be informative and useful. As always, the people of MLMIC's Risk Management and Legal departments are here to address your specific needs.

Warmest regards,

A handwritten signature in black ink, appearing to read "Tom Gray", written in a cursive style.

**Tom Gray, Esq.**

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# The Challenges of Treating “Snowbird Patients”



MLMIC would like to welcome Rafi Ejaz, Esq. as the newest member of the Legal Department team. We look forward to his contributions to the guidance and defense of MLMIC Policyholders. Please do not hesitate to contact Rafi should you have any questions on the following article, his first contribution to *The Scope — Medical Edition*.

## Who Are “Snowbirds?”

While there is no accepted definition of “snowbird patients,” the term “snowbird” denotes those individuals who travel to warmer climates to escape harsh winters. A common pattern would be those living in northeastern states wintering in southern or southwestern states such as Florida and Arizona. The number of such people is significant, with one estimate noting that Florida alone has one million residents who only spend part of the year there.<sup>1</sup>

West Florida Healthcare, for instance, experiences around a 10% increase in patient traffic when it's the winter season up north.<sup>2</sup> In response to the increase in patient traffic, Florida has had to increase spending on healthcare. The Perdido Bay Area, for example, has developed a freestanding emergency room at the cost of \$10 million.<sup>3</sup>

Many snowbirds need medical treatment while they are down south for the winter and will reach out to their providers in their home state for treatment or advice. With the advent of modern-day technology, e.g., webcams and smartphones, providing this service has undoubtedly become easier.

## The Legal Landscape — Licensing and Prescribing

Snowbird patients receiving treatment from their home state while they are down south poses legal challenges. One such issue is whether the provider in the home state is legally permitted to provide care to the snowbird patient while the patient is in another state. Generally speaking, doctors need to be licensed in the state where their patient is located at the time of the telehealth appointment.

Florida, being a hub for snowbirds, has a unique legal arrangement in place, having enacted a law

pertaining to out-of-state healthcare professionals, i.e., medical doctors.<sup>4</sup> To begin with, under the pertinent Florida statute, out-of-state doctors who are not licensed in Florida can use telehealth to deliver healthcare services to patients located in Florida if they register with the Florida Department of Health, appoint a registered agent, and meet certain other eligibility requirements.<sup>5</sup> Notably, this law only allows out-of-state doctors to use telehealth to provide healthcare rather than in-person appointments for offering their medical services.

**Generally speaking, doctors need to be licensed in the state where their patient is located at the time of the telehealth appointment.**

Telehealth is defined by Florida Statutes law, Section 456.47(4)(e), as the use of synchronous (real-time information sharing) or asynchronous (information sharing with a lag time) telecommunications technology by a telehealth provider to provide healthcare services, including, but not limited to:

- Assessment, diagnosis, consultation, treatment, and monitoring of a patient.
- Transfer of medical/dental data.
- Patient and professional health-related education.
- Public health services.
- Health administration.

Under this law, telehealth, however, does not include audio-only telephone calls, email messages, or fax transmissions, which means that out-of-state doctors would not be allowed to provide care through those means. Apart from the aforementioned, there are other arrangements in place for doctors in one state to practice in another jurisdiction, namely, the Interstate Medical Licensure Compact, which

<sup>1</sup> “10 Surprising Statistics on Snowbirds in Florida for 2023.” Florida Realty Marketplace, 19 January 2023, <https://www.floridarealtymarketplace.com/blog/10-surprising-statistics-on-snowbirds-in-florida-for-2023.html>. Accessed 7 July 2024.

<sup>2</sup> Baucum, Joseph. “Snowbirds a Challenge for Health Care Industry.” Pensacola News Journal, 8 January 2017, <https://www.pnj.com/story/money/business/2017/01/08/snowbirds-challenge-health-care-industry/9617172/>

<sup>3</sup> Ibid.

<sup>4</sup> Feldman, Sandra. “Florida Out-Of-State Telehealth Reg Law.” Wolters Kluwer, 19 February 2021, <https://www.wolterskluwer.com/en/expert-insights/floridas-out-of-state-telehealth-registration-law>. Accessed 7 July 2024.

<sup>5</sup> Florida Statutes, Sec. 456.47.

essentially creates a pathway for physicians who hold a medical license in one state to obtain a license in another.<sup>6</sup> However, to date, New York State has not joined the Interstate Medical Licensure Compact.<sup>7</sup>

### However, to date, New York State has not joined the Interstate Medical Licensure Compact.<sup>7</sup>

There are exceptions in place that allow medical providers licensed in one state to provide their services in another. One such exception is a New York state law pertaining to speech-language pathologists that allows a speech-language pathologist from another state to perform speech-language pathology or audiology services in New York as long as such services are performed for no more than 30 days in any calendar year and provided that such services are performed in conjunction with and/or under the supervision of a speech-language pathologist or audiologist licensed under Article 159 of the New York State Education Law.<sup>8</sup>

The regulatory landscape regarding telehealth is far more complicated when we look at the nationwide picture. In the wake of COVID-19, every state in the Union issued a waiver and/or developed expedited telehealth licenses, allowing residents to meet virtually with doctors.<sup>9</sup> This proved to be revolutionary in a way, as by April 2020, over a third of all doctors' appointments in the country were conducted via telehealth.<sup>10</sup> However, as fast as that change was ushered in, it was quickly backtracked on. As early as 2021, legislators and medical boards began ending waivers for telehealth access,

and many states ended up banning or severely restricting telehealth appointments with doctors licensed out of state.

Some of these states, such as Alaska, do have certain exceptions in place, such as allowing the use of telehealth to see an out-of-state doctor if you have a life-threatening condition.<sup>11</sup> Similarly, the state of Kentucky has an exception in place that allows telehealth appointments if the patient involved is a sports entity that is visiting Kentucky for a sporting event. Some states, such as New Jersey, take telehealth very seriously. Notably, in New Jersey, doctors can be subjected to criminal charges and even jail time for practicing telemedicine with an out-of-state license. Many other states fall on the opposite end of the spectrum and have a wide range of regulatory measures in place that make the use of telehealth much easier.<sup>12</sup>

Another important legal aspect worth discussing is that of online prescriptions, specifically those of controlled substances. Looking nationwide, we see a wide array of variation as to how different states approach such online prescriptions from a legal standpoint.<sup>13</sup> Some states require a patient-physician relationship to be established, even if via telehealth, before such prescriptions can be made online, whereas other states require an in-person evaluation within a specific time frame for online prescribing to take place. On the other hand, some states do not allow any online prescribing of controlled substances. It might also be worth noting that certain states, such as Arkansas and Indiana, have specific restrictions for online prescribing of abortion-inducing medications.<sup>14</sup> At the federal level, there is the Ryan Haight Online Pharmacy

6 Saley, Chad. "Interstate Medical Licensure Compact States List and Guide for 2024." CompHealth, 11 April 2024, <https://comphealth.com/resources/interstate-medical-licensure-compact>. Accessed 7 July 2024.

7 Interstate Medical Licensure Compact. Home Page, 10 July 2024, <https://www.imlcc.org/>

8 "Cross State Licensing." CCHP, 20 March 2024. <https://www.cchpca.org/new-york/?category=professional-requirements&topic=cross-state-licensing-professional-requirements>

9 Trotter, Caleb. "In 30 States, You Can't Use Telehealth With Out-of-State Doctors." Pacific Legal Foundation, 13 December 2023, <https://pacificlegal.org/30-states-telehealth-rules/>. Accessed 7 July 2024..

10 Ibid.

11 Ibid.

12 Ibid.

13 AAFP. "Legal Requirements for Telehealth" <https://www.aafp.org/family-physician/practice-and-career/managing-your-practice/telehealth-and-telemedicine/legal-requirements-for-telehealth.html>

14 Ibid.

Consumer Protection Act of 2008 and the Drug Enforcement Administration's regulations, under which a practitioner may use telehealth to prescribe a controlled substance to a patient only after having an in-person evaluation.<sup>15</sup>

Apart from the purely legal consideration, to meet the needs of snowbird patients, hospitals are entering into partnerships with each other to accommodate their patients. One such partnership is between the Northwell Health System of New York and the Boca Raton Regional Hospital of Florida, under which patients who travel from New York to Florida and vice versa can expect to continue treatment in the state they are visiting.<sup>16</sup> Such measures would undoubtedly make it easier for doctors in New York, for instance, to provide care services to a patient in Florida by facilitating their coordination. Beyond the utilization of the aforementioned measures, it would essentially be legally prohibited for a doctor in one state to provide their services in another state.

## Patient Insurance and Payment Considerations

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If any of the aforementioned measures are not able to be used by doctors from their home state, snowbird patients would have to seek coverage from a completely new healthcare provider, which would likely pose other challenges, namely, insurance and payment issues.<sup>17</sup>

If the patient belongs to a health maintenance organization (HMO), for instance, they will likely face coverage issues while traveling outside of their

home state. HMOs tend only to provide coverage for treatment that is received from doctors who are inside of their network. Generally speaking, HMOs will only cover network treatment if it is for an emergency. While some will provide coverage for treatment sought while on an out-of-town trip,<sup>18</sup> they may have very specific rules about the maximum length of a trip for which they will cover out-of-town care, whereas others may have more flexible guidelines. Under either type of rule, snowbird patients aren't likely to be covered.<sup>19</sup> Therefore, snowbird patients enrolled in HMO plans would likely have to look elsewhere for coverage.

Beyond the complications of being a snowbird patient, there are some relatively simple guidelines to be aware of. If a snowbird patient is enrolled in Medicare, they are entitled to nationwide coverage. Essentially, Medicare will provide coverage for the medical services patients receive regardless of the state they are in as long as they receive medical services from providers who accept Medicare.<sup>20</sup> For those snowbird patients who are enrolled in a Medicaid program, coverage issues can be a bit more complicated.<sup>21</sup> Unlike Medicare, Medicaid is not run solely by the federal government but is run jointly by federal and state governments. This essentially means that benefits, eligibility, and provider access vary from one state to another. Barring any exceptions, Medicaid generally only covers care received in the state that provides the Medicaid coverage. While emergency care is covered outside the state, non-emergency care is generally not covered outside of the state that provides Medicaid coverage. In order to avoid such complications, the patient is entitled to apply for Medicaid coverage

**continued on page 8**

15 Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Evaluation. (2023, March 1). Federal Register. <https://www.federalregister.gov/documents/2023/03/01/2023-04248/telemedicine-prescribing-of-controlled-substances-when-the-practitioner-and-the-patient-have-not-had>

16 cclark@healthleadersmedia.com. "NY Health System, FL Hospital Partner for Snowbird Care." HealthLeaders Media, 23 February 2015. <https://www.healthleadersmedia.com/strategy/ny-health-system-fl-hospital-partner-snowbird-care>

17 Norris, Louise. "How Health Insurance Works When You Live in Multiple States." Verywell Health, 22 July 2023, <https://www.verywellhealth.com/health-insurance-for-multiple-states-4584359>. Accessed 7 July 2024.

18 Carlson, Bob. "Solving the Snowbird Health Care Dilemma." Retirement Watch, 27 December 2018, <https://www.retirementwatch.com/solving-the-snowbird-health-care-dilemma>

19 Ibid.

20 Norris, Louise. "How Health Insurance Works When You Live in Multiple States." Verywell Health, 22 July 2023, <https://www.verywellhealth.com/health-insurance-for-multiple-states-4584359>. Accessed 7 July 2024.

21 Ibid.

## RISK MANAGEMENT TIP

The Use of Technology (High Tech, Low Risk)

# The Proper Use of Patient Portals

### The Risk

Patient portals are an effective tool to actively engage patients in their care and improve health outcomes. However, healthcare professionals must be aware of the potential risks presented by this technology. Some of these risks include reliance on the patient portal as a sole method of patient communication, patient transmission of urgent/emergent messages via the portal, the posting of critical diagnostic results prior to provider discussions with patients, and possible security breaches resulting in HIPAA violations. Implementing appropriate policies and procedures in the use of portals will enhance patient communication and mitigate liability risks for the practice.

### Recommendations

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1. Develop comprehensive patient portal policies that include:
  - Patient username and password requirements (i.e., a minimum number of characters that include capitals and nonalphabetic characters).
  - A privacy/confidentiality statement on all outgoing messages.
  - Encryption updates.
  - Account lockout after a specified number of failed login attempts.
  - A mechanism to ensure termination of user access when indicated (e.g., the patient leaves the practice, death, and inappropriate use of the portal).
  - Time frames for responding to patient communication.
  - Designated responsibility for replying to patients when the primary provider is not available.
  - A two-factor identifier system for the importation of diagnostic studies into the patient portal.
  - The monitoring of patient access to posted diagnostic results.
  - A follow-up system for patients who do not access the portal.
  - A mechanism to notify patients if the portal is not functioning properly. A notification should be placed on the practice's website and included in any prerecorded telephone message.

Consider giving family members or patient representatives their own sign-in to the portal so that all can be on board with the recommended treatment plan.



2. Advise patients of the reporting mechanisms for:
  - Email address changes.
  - Questions regarding portal use.
  - Potential errors in their information.
  - Suspected breaches of privacy.
3. Providers should not use the portal as the means to communicate critical/significant diagnostic results. Diagnostic results should not be posted to the portal until this communication has occurred.
4. Instruct patients that the portal is not to be used to evaluate and treat new problems.
5. Utilize a disclaimer on the portal that clearly states it is not to be used for emergencies/urgent problems, and include instructions for patients to call 911 or go to the nearest emergency department.
6. Consider implementing a patient portal user agreement that:
  - Defines the information patients may access (e.g., appointments, medication refill and referral requests, form downloads, routine appointment reminders, and laboratory reports).
  - Prohibits requests for narcotic medication refills.
  - States that the patient portal is the only permissible method of electronic communication with the practice.
  - Includes the disclaimer statement regarding urgent/emergent/new problems.
7. Have staff educate patients regarding the use of the portal and the contents of the portal user agreement upon patient sign-up and as necessary.

**For additional resources, please contact the attorneys of MLMIC's Legal Department.**

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MLMIC Risk Management Department • (518) 786-2815 • [RMC@mlmic.com](mailto:RMC@mlmic.com)

*The Challenges of Treating “Snowbird Patients” (continued)*

each time they move if they can establish residency according to the rules of the new state.<sup>22</sup> A very important caveat to that, however, is that just because the patient qualifies for Medicaid in one state does not necessarily mean they will qualify for it in another. To avoid any potential complications, snowbird patients can simply purchase travel insurance. If your patient is a snowbird and is concerned about having coverage, they might want to consider purchasing a domestic travel medical policy.

**If a snowbird patient is enrolled in Medicare, they are entitled to nationwide coverage.**

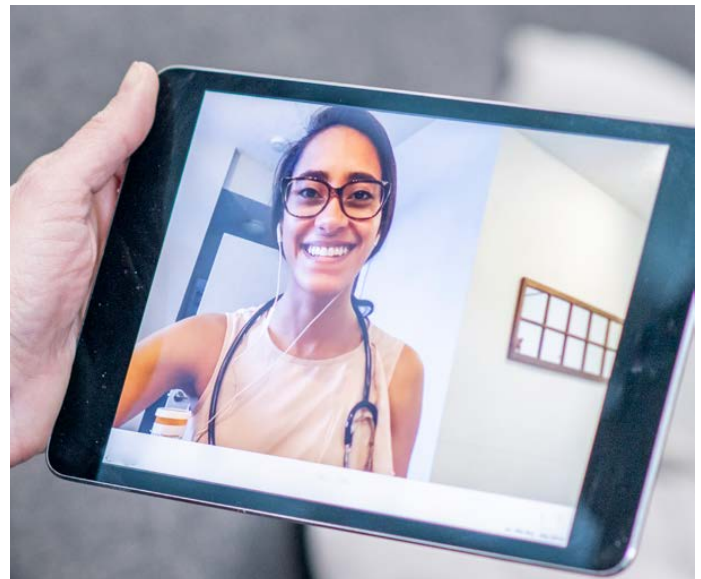
### Regulation Compliance Considerations

The benefits of telehealth can be significant. As a snowbird living in another state, the connectivity they have with their doctor from their home state would likely provide a level of comfort they would not have while going to a completely new care provider. However, the practice of telehealth on the part of doctors poses unique challenges. To begin with, providers would need to ensure they comply with the differing regulations of any and all states their patients might be in. Doctors would also need to ensure that they are in compliance with privacy and security standards for the secure transmission of protected health information between them and their patients.

Certain states, New York being one, might not have any specific laws or regulations pertaining to the standard of care for telehealth providers.<sup>23</sup> In such a situation, a court of law would have to decide the applicable standard of care as far as doctors are concerned. With that being said, however, doctors should ensure that they treat a telehealth appointment just as seriously as an in-person

appointment. Just because an appointment is being conducted via the use of telehealth does not make it any less formal. At a minimum, doctors and dentists would be expected to conform to the same standard of care in a telehealth appointment as an in-person appointment.

**At a minimum, doctors and dentists would be expected to conform to the same standard of care in a telehealth appointment as an in-person appointment.**



The three components of any applicable standard of care for telehealth appointments are compliance with acknowledged medical procedures, respect for the patient’s individuality, and regard for particular conditions and objective possibilities.<sup>24</sup> Therefore, any malpractice committed while conducting telehealth appointments would be subject to the same legal repercussions as any in-person malpractice. Any telehealth appointment should be documented just as any in-person

22 Norris, Louise. “How Health Insurance Works When You Live in Multiple States.” Verywell Health, 22 July 2023, <https://www.verywellhealth.com/health-insurance-for-multiple-states-4584359>. Accessed 7 July 2024.

23 Wheel. “New York Telehealth Regulations and Laws.” 4 April 2023. <https://www.wheel.com/state-telehealth-regulations/new-york>

24 Holčápek, Tomas., Martin Šolc, and Petr Šustek. (2023). “Telemedicine and the Standard of Care: A Call for a New Approach?” *Frontiers in Public Health*, 11, 2023. <https://doi.org/10.3389/fpubh.2023.1184971>

appointment would be, and all appropriate procedures should be followed.<sup>25</sup>

## Treatment Guidelines

So, what can doctors do to make themselves more accommodating to snowbird patients? To begin with, they should determine whether any of their patients can be classified as snowbirds. Patients should be asked, possibly as part of any intake sheet they complete, whether they spend a significant part of the year out of state. Doctors can also have their patients identify whether they have a healthcare provider out of state and obtain that other provider's contact information. The point here is that doctors should be aware of any relevant treatment the patient might have received out of state. If the patient has received any relevant out-of-state healthcare services, those records should be obtained so that a full history is available.

Doctors of snowbird patients should also make an effort to coordinate care with the patient's other provider(s). For example, as part of the care plan, providers' offices should communicate if they have a mutually common snowbird patient in order

to establish a direct conversation, should one be necessary. These measures can go a long way to ensuring continuous, effective healthcare for the snowbird patient.

**The point here is that doctors should be aware of any relevant treatment the patient might have received out of state.**

Finally, before doctors and dentists even start to offer care to snowbirds, they need to ensure that their professional liability insurance covers it. Doctors and dentists may need to purchase supplemental coverage for such care. Should you have any questions regarding your MLMIC coverage, please contact your Underwriter or call **(800) ASK-MLMIC**.



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<sup>25</sup> "Telehealth Offers Advantages for Practices, But Liability Risks Remain." NORCAL Group, 24 August 2022, <https://www.norcal-group.com/library/telehealth-offers-advantages-for-practices-but-liability-risks-remain>. Accessed 7 July 2024.



**FROM THE BLOG**

**October 28, 2024**

## **Case Study: Informed Consent Regarding Mastectomy and Breast Reconstruction: Who Makes the Final Decision?**

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### **Facts of the Case**

A 41-year-old female was diagnosed with infiltrating duct cell carcinoma of the left breast. She underwent a left breast mastectomy, node dissection, and breast reconstruction in early December of 2009. Several days prior to the surgery, the patient met with two plastic surgeons to discuss having breast reconstruction immediately following the mastectomy. Several options were discussed with her, including an abdominal/TRAM flap procedure, a latissimus flap procedure, and a free flap procedure.

The patient was obese and a “social” smoker. Because of this, she was not an appropriate candidate for the TRAM flap procedure. Nevertheless, the patient “insisted” on having this particular type of reconstruction, and the physicians agreed to perform the procedure. She was advised of the risks of this surgery, including infection, bleeding, scarring, asymmetry, wound healing complications, hernias, and the need for possible revision surgery.

[CLICK HERE TO CONTINUE READING >](#)

**October 23, 2024**

## **Healthcare Providers as Catalysts for Healthy Aging**

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With increasing lifespans, healthy aging is becoming a top priority. Healthcare providers are essential in helping patients enjoy a fulfilling and vibrant retirement.

This article looks at how healthcare providers can support healthy aging through:

**Preventative Care and Early Intervention**

**Lifestyle Counseling**

**Medication Management**

**Social and Emotional Well-being**

**And more...**

[CLICK HERE FOR THE FULL ARTICLE >](#)

**October 7, 2024**

## The Future of Healthcare: The Verdict on Value-Based Care

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Are you ready to dive into the world of value-based care? Join host Tammie Smeltz, RPLU, for the latest episode of *The Verdict*, MLMIC's podcast, as she sits down with Dr. Salvatore Volpe to discuss the intricacies and advantages of this patient-centric healthcare model.

Don't miss this opportunity to gain a deeper understanding of value-based care and its impact on the future of healthcare!

[CLICK HERE TO LISTEN TO THE PODCAST >](#)

**August 26, 2024**

## Wellness Resources for Healthcare Providers in New York: A Prescription for Balance

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The medical profession is undeniably demanding. Long hours, high-stakes decisions, and the pressure to deliver optimal patient care can take a significant toll on the mental and physical health of healthcare providers. It's no wonder that burnout rates among healthcare providers are alarmingly high. Recognizing this critical issue, healthcare institutions and organizations in New York are increasingly prioritizing wellness programs tailored to the unique needs of healthcare providers.

### The Importance of Healthcare Provider Wellness

Before diving into the specifics of wellness programs, it's essential to understand why healthcare providers' well-being is paramount:

- **Improved patient care:** A healthy and resilient healthcare provider is better equipped to provide compassionate and effective care.
- **Reduced burnout:** Wellness programs can help prevent burnout, a condition associated with decreased job satisfaction, medical errors, and even suicide.
- **Enhanced job satisfaction:** Prioritizing well-being can boost morale and job satisfaction among healthcare providers.

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Healthcare Weekly**

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**CASE STUDY:**

Indefensible  
Clinical Judgment  
Leads to Stroke



A 65-year-old male underwent transforaminal steroid injections at the C5-C6 level by a MLMIC-insured physician (anesthesiologist, specializing in pain management) over a 4-year period. Following the procedure, the patient suffered a stroke in the recovery room.

## Initial Treatment

The patient originally presented to the physician with a history of chronic cervical pain with numbness and tingling in the right upper extremity. The physician's notes indicated that attempts at conservative treatment consisting of physical therapy, acupuncture, and chiropractic manipulation were all unsuccessful.

An MRI of the cervical spine revealed bulging discs with right lateral stenosis at C3-C4, as well as a mild canal stenosis at C3-C4. In addition, at C5-C6, there was a foraminal disc protrusion and right foraminal narrowing. The physician's diagnosis was chronic cervical radiculopathy, with a plan for cervical steroid injections.

**In addition, at C5-C6, there was a foraminal disc protrusion and right foraminal narrowing.**

Over the next two visits, the physician administered two cervical epidural injections under fluoroscopic guidance and an epidurogram to assess the structure of the epidural space in the spine. However, due to lack of pain relief and numbness in his right upper extremity, the patient returned 14 weeks later, at which time the physician administered a right transforaminal steroid injection under fluoroscopic guidance and neurogram (to visualize the status of the nerves) at the C5-C6 level.

The patient did not return to see the physician until 3 years later, at which time he presented with complaints of bilateral numbness and tingling in his arms and hands. The physician's assessment was chronic cervical spondylosis, and, as such, he

performed a second right transforaminal steroid injection at C5-C6. He continued these injections during 3-, 5- and 8-month intervals, with the patient receiving a total of three right transforaminal steroid injections at C5-C6.

Three months after the last injection, the patient returned to the physician, at which time he administered the sixth right transforaminal steroid injection under fluoroscopic guidance and neurogram at the C5-C6 level. The patient advised the physician that the last procedure afforded him relief for approximately 3 months. However, at this visit, he complained of pain, numbness, tingling, weakness, and decreased sensation in both arms and hands. His pain level at this point was a 4 out of 10.

**The patient advised the physician that the last procedure afforded him relief for approximately 3 months.**

At this visit, the insured's operative report indicated that the patient was sedated with propofol and, using a 22-gauge needle, 10 ml of 1% lidocaine was injected into the skin overlying the affected neural foramen for local anesthesia at C5-C6. Using the lateral approach and AP views, a 22-gauge 3.5-inch spinal needle was advanced into the posterior aspect of the foramen at each level. With use of neurogram, Isovue 0.5 ml, 80 mg of Triamcinolone, and 2 ml of preservative-free normal saline were slowly injected at each level in equally divided doses. At the end of the procedure, the spinal needles were removed, pressure was applied along with a sterile dressing, and the patient was brought



to the PACU at 11:54 a.m. in stable condition. The procedure lasted 29 minutes.

While in the PACU, the CRNA noted that the patient was unable to move his right side on command and had clammy skin and garbled speech. His tongue was midline with right and left movement.

**He experienced a slight increase in movement of his right foot; however, he could not grasp with his right hand or lift his arm.**

A rapid response team was called, and the patient's heart rate was 27. He was given Atropine x 2 IV push and Ephedrine IV. His heart rate returned to between 80 and 100, and he was able to clearly respond to questions. Subsequently, it was noted that he could feel stimulation of his right foot, could move his toes slightly, and responded to stimuli of his right arm.

He experienced a slight increase in movement of his right foot; however, he could not grasp with his right hand or lift his arm. He could push with the right foot and wiggle his toes but could not dorsiflex, and his BP was 150/80, with a heart rate of 83.

The patient was taken for an emergency CT scan of the brain and cervical spine, as well as an MRI of the brain, which revealed a right posterior inferior cerebellar artery infarct involving the cerebellar hemisphere and medulla.

**There was no mass effect, midline shift, or focal parenchymal abnormality.**

The patient was then transferred to a Level 1 Trauma Center, where he was admitted to the stroke unit for 1 week. During this time, the MRI of the brain showed a large region of restricted diffusion

throughout most of the right cerebellar hemisphere with corresponding T2 hyper-intensity compatible with an acute infarct. There was no mass effect, midline shift, or focal parenchymal abnormality. The impression was right cerebellar infarct. An MRA of the neck revealed distal right vertebral artery signal cut-off concerning right vertebral occlusion or dissection.

Neurosurgery noted that no acute neurosurgical intervention was required. The patient was found to have a cerebellar stroke and cervical spine stroke, which was treated with hypertonic saline. The etiology of the stroke initially noted on the MRI to be a right vertebral artery dissection, but, upon further discussion, it was noted as just a normal variant, and no dissection was seen.

**There was suspicion of an ischemic process, given the signal change in the cord, the mechanism of the initial injury, and the right cerebellar infarct.**

A note from this admission indicated no hemorrhagic conversion of the right cerebellar stroke, 4th ventricle open. An addendum states that the MRI from a month later, in conjunction with repeat imaging, was reviewed and discussed. The consensus was that “the degenerative changes do not deform the cord” and, as such, were not compressive in a fashion that would be expected to cause neurologic change in this setting. There was suspicion of an ischemic process, given the signal change in the cord, the mechanism of the initial injury, and the right cerebellar infarct. As such, Neurosurgery did not believe it would be of benefit to perform decompressive intervention at C3-C4 at that time.

## Lawsuit Filed

The patient brought a lawsuit 2 years later against the MLMIC-insured physician, his practice, and the

MLMIC-insured hospital. He claimed lower extremity weakness, including ambulatory problems with his right leg, foot drop, and a neurogenic bladder requiring self-bladder catheterization multiple times per day.

**The patient brought a lawsuit two years later against the MLMIC-insured physician, his practice, and the MLMIC-insured hospital.**

At issue was whether the epidural steroid injection and the transforaminal steroid injections were indicated, if the proper informed consent for these procedures was obtained, whether our insured injected the vertebral artery when he performed the last transforaminal steroid injection, and whether it was appropriate to perform the transforaminal steroid injections at the C5 and C6 levels, where there is a known increased risk of stroke. Another issue was whether our insured caused a cerebral artery dissection.

MLMIC’s experts confirmed on imaging that there was an improper positioning of one of the needles, and they felt that the vertebral artery occlusion was a result of this procedure.

The location of the needle and the timing of the event that occurred immediately after the procedure, as well as the location of the infarct, supported a causal relation to the injection. Small infarcts within the cord on MRI were further evidence that the injection caused the infarct, with the major infarct at the interior inferior C6 level.

Our reviewers further opined that the resultant CVA and spinal cord infarction were not acceptable complications from a cervical transforaminal steroid injection, and thus our insured did not meet the standard of care due to his choice of a particulate steroid, the controversial performance of a transforaminal steroid injection in a patient with cervical radiculopathy, and for not insisting the patient be seen by a neurosurgeon.

## Conclusion

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A summary judgment motion was granted on behalf of the hospital.

**The plaintiff claimed damages exceeding \$4,000,000.**

The plaintiff claimed damages exceeding \$4,000,000. A decision was made to settle on behalf of our insured, with the plaintiff ultimately accepting an amount within the insured's policy limits. The practice and the hospital were subsequently discontinued from the case.

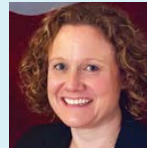
## A Legal and Risk Management Analysis

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This case demonstrates the importance of defensible clinical judgment in a malpractice action. In legal terms, an error in clinical judgment is viewed more leniently than negligence. If the insured's decision-making aligned with accepted medical practices, and other professionals would have made the same choice in similar circumstances, then the insured's decision to perform a transforaminal steroid

injection in a patient with cervical radiculopathy may have been considered a reasonable action, regardless of the adverse outcome.

Expert witnesses are critical to a successful clinical judgment defense. In this case, MLMIC's experts could not support an argument that the physician's judgment aligned with acceptable medical practices. Without expert support, the plaintiff's argument that the error lay in negligence rather than acceptable clinical judgment would have been difficult to defend at trial and resulted in a significant settlement.



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