INBRIEF

Current Developments in Maine Law

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Index

Medicare Set-Asides: Are You Paying Too Much?

By: Stephen Hessert, Esq.

STEPHEN HESSERT

Background

Medicare came into being in 1935 as part of the original Social Security Act enacted by Congress. It was described as "a federally funded health insurance program for the elderly and the disabled." Over the years, its cost became problematic and in the late 1970s, a General Accounting Office study suggested that forty-one billion dollars of Medicare benefits were being used to subsidize other insurance programs such as workers' compensation and liability insurance. Consequently, in 1980, Congress passed the Medicare Secondary Payor Act which required beneficiaries to exhaust all other health insurance options before Medicare would pay benefits. Those other options include insurance for workers' compensation, liability, auto etc. The Act provided that Medicare would make "conditional payments" and provide benefits if the other carriers initially denied liability, but it is required that Medicare be repaid if other benefits are found to be applicable.

In the workers' compensation arena, a Medicare set-aside arrangement (MSA) is necessary to account for the future medical component of the primary payor's responsibility. MSAs are the tool used to account for the future medical expense associated with injuries, in order to avoid shifting responsibility for future medical from the primary payor to the Medicare

system. This article will briefly touch on two separate issues. The first will be to describe the appeal process for dealing with contested conditional payments. The second will deal with the question of whether too much is being set-aside in providing for Medicare's future interests.

Conditional Payments

Conditional payments are made by Medicare based upon diagnosis codes. The Centers for Medicare and Medicaid Services (CMS) will attribute certain diagnosis codes to an injury. In workers' compensation, it will depend upon the diagnosis of the injury, but will also include any payments for any diagnoses that are made voluntarily and without prejudice. These potentially unrelated codes/conditions become part of the liability for the work injury in Medicare's point of view.

Once liability for a primary payor is "demonstrated" by either an acceptance of liability or by settlement of the claim, conditional payments must be addressed. The parties should request that the case be put into the "final conditional payment process" which notifies the CMS Benefit Coordination and Recovery Center that the case is within 120 days of settlement. A request may be made for a final conditional payment amount within three business days of settlement via the Medicare Secondary Recovery portal. Once you have that amount, the question becomes whether it is an accurate description of the medical costs of the consequences of the actual injury, or whether it includes other treatment for which there should be no liability, either in a liability case or in the workers' compensation arena.

Appeal Process

The law is now clear that workers' compensation administrative bodies and state courts lack subject matter jurisdiction over Medicare Secondary Payor (MSP) reimbursement disputes that have not been fully exhausted through the mandatory Medicare appeal process. Any challenge to MSP's entitlement "arises under the Medicare Act" and the appellant, or the Medicare enrollee, must first proceed with an administrative appeal prior to any judicial review. *See, e.g., 42 U.S.C. §405(g-h) §1395w-22g5; 42 C.F.R. §422.560-422.612.* That appeals process has five steps:

1. The parties must appeal the conditional payment demand letter within thirty days.
2. The appealing party will receive an independent outside entity review (qualified independent contractor) that contracts with CMS to do this work.
3. If the result from the independent qualified contract review is unfavorable, an Administrative Law Judge hearing may be requested.
4. If the Administrative Law Judge hearing produces an adverse result, the party may appeal to a Medicare Appeal Council, if the ruling is adverse to the appellant and exceeds a threshold amount ($1,000).
5. Finally, if the ruling is still adverse, an appeal may be made for federal judicial review, to the Federal District Court in the appropriate jurisdiction. From there, an appeal can be taken to the Circuit Court of Appeals and possibly to the United States Supreme Court.

The important point is that absent a timely utilization of this appeal process, there is no possibility of attacking the issue of whether a conditional payment was, in fact, for the workers' compensation injury or automobile accident in question in any state proceeding, or whether other defenses such as the statute of limitations are available. Any factual issues will be resolved either through the initial administrative steps of the appeal process, or before the Administrative Law Judge.

Are You Paying Too Much?

Accounting for Medicare's interests for future medical expense for an injury is a well-developed process in workers' compensation. CMS has established work review thresholds of $25,000 for a current Medicare beneficiary, or $250,000 and the potential that the Medicare beneficiary is likely to become enrolled in Medicare within thirty months, for workers' compensation cases. If those thresholds are met, CMS will review a future MSA proposal and will provide an opinion that the parties can rely upon in settling their case. This conventional practice of submitting an MSA proposal to CMS for review and approval, which is entirely voluntary, predictably inflates costs and over burdens claim payors. In 2017 alone, some 26,000 claims had an average of about $93,000 each set aside as funds to reimburse Medicare for future medical treatment.

Care Bridge International, a vendor that does work on MSAs recently did a study focusing on the actual spending on behalf of an injured worker for the first five years post MSA report approval. Their finding was that in the fifth year post settlement, the pace of medication spending was 64% of the forecast and 55% for all other medical care. In another study, they analyzed a huge database of eight million non-settled workers' compensation claims noting the medical spending for up to eleven years after injury.

Why the inflated numbers?

1. Medicare requires that medications be priced unrealistically high at RED BOOK average wholesale price. Most claims payors pay for drugs with pharmacy benefit managers and arrange for prices that are up to 35% lower.
2. Medicare unrealistically requires that medications be budgeted unaltered for the projected life of the worker. There is no scientific assurance that this will be the case.
3. Medicare requires that treatment the worker is receiving or has planned, as of the time of settlement, will continue but, in reality, treatment evolves as patients adapt.

MSA vendors are learning this and using it to their advantage.

There are several vendors who now will produce an MSA proposal and recommend that it not be submitted to CMS regardless of whether it falls within the work-review threshold. Those vendors offer to stand behind their proposal and take over and pay if CMS rejects their analytics and if, in fact, payment exceeds the amount proposed. It is my understanding that they are developing or utilizing an insurance product for this purpose. Moreover, in some states, MSAs that are structured are being negotiated with consideration given to making the beneficiary the insurance carrier or the self-insured employer, rather than the claimant's estate. These products are new to the market, but should be considered as potential cost savings can be significant.

"Three May Keep a Secret, if Two Are Dead"[1]

How the secrets in our medical records may find themselves in someone else's courtroom.

By: Jennifer A.W. Rush, Esq.

JENNIFER A.W. RUSH

Virtually every adult in America is likely familiar with the basic concept that we hold privacy interests in the information contained within our health records. Most people hold the expectation that what you tell your physician should stay confidential and should only be released to those who have a need and right to know. But who has a need and right to know the secrets and confidences that are contained in our medical records? Some exceptions to the general rule of confidentiality are rooted in common sense. For instance, a "covered entity"[2] may disclose "protected health information"[3] to a public health entity without the consent of the patient, so long as the public health entity is allowed, by law, to collect that information in order to prevent or control disease, injury, or disability. 45 C.F.R. § 164.512(b)(1)(i). So, for example, if you develop tuberculosis, that information may get shared by your health care provider to an agency such as the Center for Disease Control without your prior authorization. Protected health information may also be shared, without the patient's consent, with a health oversight agency responsible for legally appropriate oversight activities. 45 C.F.R. § 164.512(d)(1). In other words, if DHHS wants to come in to make sure the hospital you were treated at complies with certain regulatory provisions, it may access your medical records without your prior authorization.

These types of exceptions to the general rule against disclosing protected health information without the consent of the patient make sense. Sometimes, the public interests weighing in favor of disclosure outweigh the individual interest in privacy. Most people who go to their doctor and talk about their personal, potentially embarrassing, health care information *do not*, however, expect that their medical records will be marked as exhibits and put on display in front of a jury *in someone else's* personal injury lawsuit. That type of disclosure appears unrelated to any overwhelming public interest. And, yet, this was the exact request made by the Plaintiff in the recently decided Law Court case, *McCain v. St. Joseph's Hospital*, 2018 ME 118 (August 14, 2018).

In November 2015, Ms. McCain's surgeon unintentionally injured her bile duct in the course of removing her gallbladder. *Id.* ¶ 4. In her claim against her surgeon and the hospital where he performed the surgery, Ms. McCain claimed that the surgeon was required to take specific steps to ensure that he had obtained the "critical view of safety," thereby identifying the essential structures before making any cuts, and that he failed to do so. In order to determine whether the surgeon had a habit or practice of obtaining the "critical view of safety" when performing laparoscopic cholecystectomies (minimally invasive method of removing the gallbladder), the Plaintiff sent the Defendants a request for:

> The operative notes for each and every laproscopic [sic] cholesesectomy [sic] performed by Dr. Vanadia in 2015 with names and any identifying information for the individual patients redacted to preserve patient confidentiality.

Id. ¶ 6. In other words, the Plaintiff wanted access to the operative notes for what turned out to be 103 patients who had no interest in the outcome of the litigation.

The Defendants refused to produce the documents, prompting the Plaintiff to file a motion to compel. The motion was referred by the Panel Chair to the Superior Court, which issued a compulsion order requiring the hospital and surgeon to produce portions of the operative notes for the 15 patients who had laparoscopic cholecystectomies before Ms. McCain and the 15 patients who underwent the same procedure after she did. *Id.* ¶¶ 6-7. The Defendants appealed the Superior Court's compulsion order to the Law Court, which issued its decision this past August.

Unfortunately, according to the Law Court, the procedural oddities of the case precluded a decision on the merits. Because (1) the discovery dispute arose during the medical malpractice screening panel phase of the litigation, (2) the parties proceeded to a panel hearing without the discovery and the screening panel phase had concluded, (3) a complaint had been filed, and (4) the

discovery request had not yet been renewed, the Law Court held that the discovery order had lost its validity and the dispute was moot. *Id.* ¶¶ 13-14. In handling the appeal in this way, the Court left many questions unanswered and created new ones.

First, the *McCain* appeal was positioned to provide guidance on a question left open by the Court's decisions in *Gafner v. Down E. Cmty. Hosp.*, 1999 ME 130, ¶ 12 n.4, 735 A.2d 969, and *Estate of Cox v. E. Me. Med. Ctr.*, 2007 ME 15, ¶ 6, 915 A.2d 418 – specifically, whether a panel discovery order compelling the production of a privileged document may be subject to immediate appellate review. Had the Law Court concluded that the McCain compulsion order retained its validity post-panel, it would have been required to answer the question left open by Gafner and Cox. Unfortunately, that question is still unanswered.

Further, the Court inexplicably concluded that although most panel discovery orders would still be effective in a post-panel proceeding, *this* order was no longer effective. *McCain*, 2018 ME 118, ¶ 14. Without providing clear guidance as to the reasons why this particular order was no longer effective when others would be, the Court rationalized that by conducting a panel hearing without the documents, the "records were apparently deemed not sufficiently relevant to the plaintiff's case." *Id.* Moreover, because "the assessment of the relevance of the records may have changed as the litigation progressed," this particular discovery order was no longer valid. *Id.* Accordingly, as a result of *McCain*, we have a new area of unsettled law; medical malpractice litigants and Superior Courts are now left wondering which discovery orders will be enforced post-panel and which ones should be considered moot.

Because the Law Court deemed the compulsion order moot, it did not reach the question of whether an exception to the final judgment rule would permit appellate review of an order compelling the production of non-party medical records. And, more importantly, it offered little in the way of guidance on the ultimate issue – should non-party medical records be discoverable in personal injury cases without the patients' consent or knowledge?

The one dissenting justice – Justice Alexander – left no room for interpretation as to how he would have answered the ultimate question. He concluded that "[o]pen-ended fishing expedition discovery, invading other patients' privacy and authorizing review of confidential medical records to see if those records contain information that might support an individual plaintiff's medical negligence claim, violates M.R. Evid. 503 and violates federal and state statutes mandating patient privacy and the confidentiality of patients' medical records." *Id.* ¶ 33. It is not clear, however, how many others on the Court share the same view.

To be fair to the Plaintiff, the law around the country is split on this issue. Some courts have held that so long as the medical records are redacted, they no longer contain "protected health information" and need not be classified as confidential and privileged. *See, e.g., Staley v. Jolles*, 230 P.3d 1007, 1013 (Utah 2010). Those decisions, however, provide inadequate guidance on the issues of how redactions should be accomplished and at what burden. Just because most health care providers store patients' health care information electronically does not mean that the production of medical records involves a simple "push of a button." In many respects, because of the multitude of different ways patient information is electronically stored and maintained, and due to the ever-changing technology used by health information maintenance systems, pulling an operative note from a paper file is far easier. In *McCain*, by estimate, it would have taken 8.58 hours of time to just pull the records the Plaintiff requested. It would have taken at least that long to redact those records, resulting in the dedication of over two days of time to a task that had arguably marginal relevance to the litigation.

Further, the opinions from courts who have ordered the production on non-party patient records do not fully appreciate how easily a person can be identified from the information in a health care record, even when names are removed. This is especially true, given the small patient populations in many areas of Maine.

For these reasons, in addition to the policy objectives behind state and federal privacy laws (*see* 22 M.R.S. § 1711-C and 45 C.F.R. § 164.502), as well as the evidentiary privileges safeguarding communications between patients and healthcare providers (*see* M.R. Evid. 503), several courts have held that a health care record does not become a public document just because the patient's name is removed. For instance, in *Glassman v. St. Joseph Hosp.*, 631 N.E.2d 1186 (Ill. App. Ct. 1st Dist. 1994) the plaintiff sought the records of any patient who underwent surgery by the defendant surgeons and who experienced outcomes similar to the patient's. In denying the patient's request, the Court held that even if the patients' names and identifying numbers were deleted from the records, the records were protected by the patient-physician privilege. *Id.* at 1198-99.

Likewise, in *In re Columbia Valley Regional Medical Center,* 41 S.W.3d 797 (Tex. App. Corpus Christi 2001), the Texas Court of Appeals granted relief from an order compelling the production of nonparty labor and delivery notes. In so holding, the Court explained that the purpose of the privilege was "to allow for complete communication without fear of disclosure, so that the professional can effectively render services." *Id.* at 801. Once a document becomes privileged, the privilege extends to the entire document, and not just the portion that would identify the patient. *Id.* Accordingly, redaction was insufficient to divest a document of its privileged status. *See also Baker v. Oakwood Hosp. Corp.*, 608 N.W.2d 823 (Mich. App. Ct. 2000) (in wrongful discharge action, court denied request for patient medical records on the basis that the redaction of the patients' names did not strip the records of their privileged status).

The information contained in non-party patient records may be useful to either side in the context of not just medical malpractice cases, but in other personal injury cases, discrimination cases, and workers' compensation cases. Thus, it seems likely that the Law Court will be required to address the issue in the near future. In the meantime, any request for non-party medical records should be approached carefully – by both the requesting party and the producing party. Without question, very few people voluntarily publish information regarding their physical health, mental health, social behaviors, finances, and family history. Medical records contain all of this information, and more. Not surprisingly, then, studies have demonstrated that patient distrust of the security of health care information impacts patient willingness to access the health care system. Accordingly, the position that we took in *McCain* on behalf

of all of the healthcare providers that we represent is that the privacy associated with an individual's health care information must be safeguarded.

1 Benjamin Franklin, Poor Richard's Almanac, 1735.

2 A covered entity is defined by federal law as: "Covered entity means: (1) A health plan; (2) A health care clearinghouse; (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." 45 C.F.R. § 160.103.

3 Protected health information is defined by federal law as "individually identifiable health information," with some exceptions. 45 C.F.R. § 160.103. Individually identifiable health information is defined by federal law as:

[I]nformation that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Workers' Compensation: Law Court and Appellate Division Decisions

By: Stephen W. Moriarty, Esq.

STEPHEN W. MORIARTY

Disputed Medical Treatment

The injured worker sustained an occupational low back fracture and continued to experience back and leg symptoms following surgery. His primary care provider prescribed narcotic pain medication. There was conflicting evidence concerning the effectiveness of the medication, and both the employee's physiatrist and the employer's Section 207 examiner indicated that the use of narcotic pain medication was not justified.

The employer apparently declined to pay for the medication and the employee filed a Petition and Payment. The ALJ found that the long-term use of narcotics was inappropriate and that the continuation of such medication was not reasonable or necessary. The ALJ rejected the employee's opinion that the benefits of the medication were greater than the risk of long-term dependence.

The employee appealed and in *Martin v. George C. Hall & Sons, Inc.* Me. W.C.B. No. 18-26 (App. Div. 2018) the Division rejected the employee's argument that Section 206 of the Act did not empower an ALJ to make a risk-benefit analysis in determining the type of medication for which an employer was responsible. In his testimony the employee had stated that the benefit of the medications was marginal and that he experienced significant side effects. The Division ruled that the benefits experienced compared to the inherent risks of a particular medication are relevant in determining whether a medication is both reasonable and proper within the meaning of Section 206. Although the Division assumed that the prescribing physician felt that the medication was appropriate, it held that the medication was not. Thus, the Division concluded that the ALJ properly considered both the risks and side effects of the medication in determining whether or not it was proper, and the denial of the compensability of the medication was upheld.

Waiver of Objection to Treatment of Section 312 Report

In December 2010 Sullivan & Merritt hired three ironworkers to work on a boiler renovation project at a paper mill. The project consisted of two phases, the first of which involved the removal of paint while the boiler was in operation and producing a byproduct from pulp production. The second phase involved metal work on the interior of a boiler to replace portions that had become "welded" to the boiler by virtue of the heat that was produced when in operation. The particular details of the two phases were numerous, and suffice it to say that according to the employees' testimony they were exposed to extensive amounts of smoke, dust, soot, ash, and related byproducts during the renovation project. By the end of December 2010 all three individuals felt sick and shortly after were terminated. Each ironworker filed a Petition for Award, and the claims were consolidated.

In *Lenfest, et al v. Sullivan & Merritt,* Me. W.C.B. No. 18-25 (App. Div. 2018) a section 312 physician with a specialization in pulmonary medicine preformed an exam of each individual, he concluded that all were fit for duty. The physician only briefly addressed the issue of toxic exposure and did not offer an opinion on possible psychological consequences of the claimed injuries.

The section 312 exam had taken place fairly early in the process, and in the time period following the exam extensive treatment took place and a large volume of medical records was developed. The treatment records included reports from a physician specializing in internal medicine and occupational environmental medicine. This physician found that there were chronic neurologic consequences from toxic exposures at the mill, and that the three individuals were also psychologically incapacitated as the result of the work they performed. Surprisingly, neither party offered the new medical records to the section 312 examiner for review and comment and as a result there was no supplemental report.

The ALJ granted the Petitions for Award relying upon the testimony of the employees' physician, but did not specifically comment upon how her opinion provided clear and convincing evidence contrary to that of the Section 312 examiner. The employer's Motion for Findings of Fact was denied and the employer appealed.

On appeal the employer argued that the ALJ incorrectly rejected the section 312 examiner's conclusions on the grounds of subsequent medical evidence that was not provided to the examiner. The Division found that the employer had not raised this issue at the hearing level, and that therefore the challenge was waived. Without an underlying objection, it was inappropriate for the employer to raise the issue for the first time on appeal. In effect, the Division side-stepped the issue of ALJ reliance upon post-section 312 treatment by relying on the employer's failure to have raised the issue at hearing.

On an unrelated issue, the Division ruled that the ALJ did not commit reversible error by refusing to sequester the employees from observing the hearing after they had testified. As parties to the proceeding, the individual employees had the right to observe and assist legal counsel during the proceedings after they had testified.

Finally, the employer argued that the claimants should not have been awarded benefits for total incapacity during a period of time in which they also received unemployment benefits. The employer argued that an applicant can only qualify for unemployment benefits if he or she is able to work and that therefore a recipient of unemployment benefits cannot as a matter of law be found to be totally incapacitated under the Act. Relying upon *Page v. General Electric Company,* 391 A.2d 303 (Me. 1978), the Division found that this issue had already been decided adverse to the employer and that "an award of unemployment benefits from the Department of Labor does not have a preclusive effect on the Workers' Compensation Board." Therefore, the receipt of unemployment benefits did not prevent an award of workers' compensation benefits for total incapacity.

The decision of the ALJ was upheld in its entirety.

"THE DIVISION RULED THAT THE BENEFITS EXPERIENCED COMPARED TO THE INHERENT RISKS OF A PARTICULAR MEDICATION ARE RELEVANT IN DETERMINING WHETHER A MEDICATION IS BOTH REASONABLE AND PROPER WITHIN THE MEANING OF SECTION 206."

Recent Decisions From The Law Court

By: Matthew T. Mehalic, Esq., CPCU

MATTHEW T. MEHALIC

No Liability Coverage Under Homeowner's Policy for Premeditated Assault

In *Vermont Mutual Insurance Company v. Jonathan Ben-Ami, et al.*, 2018 ME 125 (August 21, 2018), the Law Court addressed whether the expected or intended injury exclusion applied where an individual carried through a premeditated attack on another. James Poliquin, Esq. of Norman, Hanson & DeTroy, LLC represented Vermont Mutual on this claim and successfully argued that the exclusion applied.

The case arose out of Joshua Francoeur's attack on a fellow high-school student, Jonathan Ben-Ami. The two individuals had a verbal altercation at a football game several days before the attack. Francoeur was encouraged by his friends to plan an attack on Ben-Ami. During the school day, Francoeur went to Ben-Ami's classroom. The door to the classroom was locked, but Francoeur was able to convince the teacher to open the door. Francoeur went up behind Ben-Ami who was wearing headphones and punched him repeatedly in the face resulting in injuries and a broken jaw.

Francoeur's father had a homeowner's policy with Vermont Mutual. The policy included an exclusion for expected or intended injury which provided in pertinent part that coverage was excluded for "bodily injury... which is expected or intended by the insured." *Id.* at ¶ 12. Ben-Ami filed a complaint against Francoeur and Vermont Mutual provided a defense under a reservation of rights based on the expected or intended injury exclusion and on other grounds not addressed by the Law Court on appeal. Eventually, Ben-Ami and Francoeur agreed to a stipulated judgment with a covenant not to execute against the personal assets of Francoeur. Ben-Ami proceeded solely against any liability coverage that was provided under the Vermont Mutual policy. Vermont Mutual filed a declaratory judgment action on the basis of the application of the exclusion, among other reasons, and Ben-Ami filed a reach-and-apply action against Vermont Mutual. The two matters were consolidated.

The Superior Court denied Vermont Mutual's motion for summary judgment and held a bench trial on the applicability of the expected or intended injury exclusion and ruled in favor of Ben-Ami. The Superior Court did not conclude that Francoeur "subjectively intended to inflict the level of damage that ultimately was inflicted upon Mr. Ben-Ami in the form of his broken jaw." *Id.* at 6. Furthermore, the Superior Court determined that, "Mr. Francoeur's testimony that he did not consider the consequences of his action or consider the likelihood that his punching of Mr. Ben-Ami would produce a serious injury [was] credible." *Id.* Vermont Mutual appealed the Superior Court's decision.

The Law Court framed the dispositive issue as "whether the evidence compelled the court to find that Francoeur either "intended or expected" bodily injury to Ben-Ami, which would trigger the exclusion." *Id.* at ¶ 14. The Court determined that the evidence did compel such a finding.

Crucial to the Courts determination were the following facts:

> Francoeur and Ben-Ami had had a hostile verbal encounter several days earlier; Francoeur then developed a plan to attack Ben-Ami; in execution of that plan, Francoeur left his classroom and proceeded to another classroom where Ben-Ami was present; Francoeur induced the teacher to unlock the door in order to allow him into the classroom; Francoeur approached Ben-Ami from behind so that Ben-Ami, who had headphones on, was "likely unaware" of the imminent attack; Francoeur punched Ben-Ami about the face with a closed fist "multiple times"; and, as the direct result of the assault, Ben-Ami sustained serious injuries, including a broken jaw.

Id. at ¶ 15. The Court could not rectify these facts with the Superior Court's findings that Francoeur did not consider the consequences of his action or did not subjectively intend the extent of damage he could, and did, cause. "Given the premediated nature of the assault, the ambush tactic that Francoeur used, and the location and magnitude of the resulting injuries, the evidence compelled the court to find, at the very least, that Francoeur must have subjectively foreseen as practically certain (i.e., expected) that his deliberately

violent conduct would result in bodily injury to Ben-Ami." *Id.* at 17.

Despite the Court's decision in favor of Vermont Mutual, the Court refused to categorically hold that an assault, as that at issue in the matter, always fell within the expected or intended exclusion without consideration of the subjective intent or expectation of harm of the perpetrator, as was requested by Vermont Mutual.

In a concurring opinion, Justices Mead, Alexander and Jabar, three of seven Justices on the panel, agreed with the Court's entry of judgment in favor of Vermont Mutual, but wished that the Court had gone further, as requested by Vermont Mutual. "I would go further and conclude that this factual scenario – the intentional striking of an unsuspecting person in the face with a closed fist – leads to a conclusion that as a matter of law the physical injuries resulting from the attack were intended and expected." *Id.* at ¶ 25. The concurring Justices wished to do away with an examination of the subjective intent of the perpetrator under these circumstances when determining if the expected or intentional injury exclusion applied.

Decision to Discharge Patient Appropriate and Medical Malpractice Prelitigation Screening Panel Not Equivalent to Trial

In *Randy N. Oliver, II et al. v. Eastern Maine Medical Center,* 2018 ME 123 (August 21, 2018), the Law Court addressed whether EMMC was negligent when it discharged an individual despite contrary instructions given by the individual's limited guardians to the hospital. The Superior Court entered judgment in favor of EMMC and the Law Court affirmed holding that EMMC was not negligent.

The case arose out of the hospitalization of an individual, Randy Oliver. Randy was found severely intoxicated at his home and was taken to EMMC by his daughter and his ex-wife. The conditions of Randy's home were unsanitary, there was no running water, and there were a number of fire hazards. Randy was admitted with diagnoses of liver-related brain damage, possible alcohol withdrawal, deterioration of functional status, and a neglected state. He also had burns on his hands. The day after his admission, a psychiatrist conducted an evaluation of Randy, at which Randy expressed that he did not understand why he was at the hospital. The evaluation concluded that Randy's alcohol addiction was potentially lethal, that he suffered from significant cognitive impairment, and that a guardian might need to be appointed. About a week later another evaluation was performed by a neuropsychologist that concluded that Randy lacked the capacity to manage simple or complex finances independently or make informed decision about his health.

Randy's son and daughter filed a petition with the Probate Court to be appointed Randy's co-guardians. After a hearing Randy's son and daughter were appointed as co-guardians. However, the appointment was limited in that the guardians were authorized to "act only as necessitated by [Randy's] actual mental and adaptive limitations or other conditions warranting this procedure." *Id.* at ¶ 9.

Over the course of Randy's two month hospitalization his condition improved and he expressed that he wanted to leave the hospital. Another neuropsychological evaluation was performed. The evaluation indicated that Randy was alert, friendly, pleasant, and very cooperative. Randy was noted as "strikingly different" from the earlier evaluation. It was concluded that Randy had the capacity to "manage simple or complex finances independently" and "make better informed decisions regarding his health." *Id.* at ¶ 10. Randy had also indicated that he planned to quit drinking.

Based on the evaluation, EMMC concluded that Randy "no longer needed acute medical care and that the hospital was possibly holding him there against his will." *Id.* at ¶ 11. Randy's son and daughter, his limited guardians, disagreed with the evaluation findings and disapproved of Randy's discharge from the hospital. EMMC offered to have another evaluation performed by another practitioner, but the guardians informed EMMC that they did not want another evaluation. EMMC ultimately discharged Randy based on the Probate Court's order providing limited guardianship to Randy's son and daughter only where Randy was unable of making decisions and Randy's request to be discharged. When Randy was discharged a plan was generated that included a referral to Randy's primary care provider, a pain clinic, community case management, and a recommendation to participate in substance abuse treatment. Randy's son and daughter were informed by EMMC of Randy's discharge on the date of discharge.

Randy's son and daughter visited Randy twice over the course of the night and when they left him the last time he was intoxicated. Randy died later that night as the result of a fire.

Randy's son and daughter, individually and as personal representatives of the estate filed a complaint in the Superior Court against EMMC based on negligence for breach of the standard of care. Judgment was entered in favor of EMMC. An appeal

"DESPITE THE COURT'S DECISION IN FAVOR OF VERMONT MUTUAL, THE COURT REFUSED TO CATEGORICALLY HOLD THAT AN ASSAULT, AS THAT AT ISSUE IN THE MATTER, ALWAYS FELL WITHIN THE EXPECTED OR INTENDED EXCLUSION WITHOUT CONSIDERATION OF THE SUBJECTIVE INTENT OR EXPECTATION OF HARM OF THE PERPETRATOR, AS WAS REQUESTED BY VERMONT MUTUAL. "

was filed by Randy's son and daughter.

The issues raised on appeal were whether the Superior Court erred in: (1) "concluding that the Probate Court's guardianship order did not preclude EMMC from discharging Randy, given the contrary instructions they had given in their capacity as Randy's court-appointed guardians"; (2) "concluding that Randy had regained capacity to make the decision to be discharged"; and (3) "concluding that EMMC's discharge plan was reasonable." *Id.* at ¶ 26.

With regard to the first issue, the Law Court held that the Superior Court was correct in concluding that the Probate Court guardianship order did not preclude EMMC from discharging Randy. The guardianship order was a limited guardianship order, pursuant to 18-A M.R.S. § 5-105. This section allows appointment of a guardian with fewer than all of the legal powers and duties of a guardian. In addressing healthcare decisions, per the Probate Code, the limited guardian is to make decisions in accordance with the ward's individual instructions when the ward has capacity. *See* 18-A M.R.S. § 5-312(a)(3). Furthermore, the healthcare provider, per the Uniform Healthcare Decisions Act contained within the Probate Code, is to presume capacity and when capacity is lacking if the individual regains capacity the healthcare provider is to communicate the determination to the patient and any other person authorized to make decisions on behalf of the patient. Because of the determination by the healthcare provider that Randy had regained capacity and because of the limited scope of the Probate Court guardianship order, EMMC was not precluded from discharging Randy.

In regards to the second issue, the Court concluded that EMMC met the standard of care involved in concluding that Randy regained capacity. Having the same neuropsychologist evaluate Randy upon the initial admission and almost two months later in order to compare the condition of Randy met the standard of care. Also, the other EMMC providers that had interacted with Randy during his hospitalization also concluded that he had regained capacity. The medical records supported Randy's improvement and regaining of capacity. The expert witnesses called by EMMC to testify also supported that the EMMC met the standard of care for evaluating whether Randy had regained capacity to make the decision to be discharged.

Finally, with regards to the third issue, the Court concluded that the discharge plan was safe and reasonable. Appointments were scheduled for Randy to a pain clinic and his primary care physician. Information was provided for case management services. EMMC also gave strong recommendations that Randy stop drinking, attend group meetings, and EMMC even offered substance abuse counseling. Randy's acknowledgment that he needed to stop drinking was evidence that the discharge plan was appropriate. Therefore, the discharge plan was held to be safe and reasonable and not negligent. Judgment in EMMC's favor was affirmed.

Another issue involved in the appeal, was whether the Superior Court had erred when it refused to award EMMC its expert costs incurred during the medical malpractice prelitigation screening panel process. Title 14 M.R.S. § 1502-C allows the courts within their discretion to award reasonable expert witness fees and expenses as allowed under 16 M.R.S. § 251. Section 251 provides in pertinent part, "The court in its discretion may allow at the trial of any cause, civil or criminal, in the Supreme Judicial Court, the Superior Court or the District Court, a reasonable sum for each day's attendance of any expert witness or witnesses at the trial." Due to the confinement of section 251 to "trial" in a court, the Law Court held that the prelitigation screening panel proceeding was not a "trial" that permitted the courts to award expert witness fees and expenses incurred in the panel proceeding.

New Associate

We are pleased to announce that Trevor D. Savage joined the firm as an associate in September 2018. Trevor is a Maine native who attended Noble High School and graduated from Emerson College, where he studied sports broadcasting and covered the Patriots, Red Sox, Bruins, and Boston collegiate sports teams.

Before joining Norman, Hanson & DeTroy, Trevor served as a law clerk to the Honorable Joseph M. Jabar of the Maine Supreme Judicial Court. He graduated from the University of Maine School of Law, where he served as Managing Editor of the Maine Law Review and as a legal writing teaching assistant for first-year students. During law school, Trevor competed nationally as a member of the Maine Law Moot Court Team—placing first runner-up out of 41 teams at the 2017 Robert F. Wagner Labor and Employment Law Moot Court Competition—and worked as a Student Attorney at the Cumberland County District Attorney's Office. Trevor also interned at the United States Attorney's Office and with Judge Kermit V. Lipez of the United States Court of Appeals for the First Circuit.

Trevor and his wife, Amy, life in Yarmouth with their son, Jacob, and their golden retriever, Penny. In his spare time, he enjoys salmon fishing, scuba diving, skiing, and hiking.

TREVOR D. SAVAGE

NHD Attorney Designated as "Lawyer of the Year"

James D. Poliquin
Bet-the-Company Litigation

James D. Poliquin has been designated by Best Lawyers as the "Lawyer of the Year" for 2019 for the greater Portland area. We congratulate him for having achieved this impressive recognition.

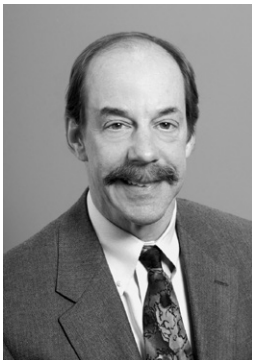
NHD Attorneys Listed in "Best Lawyers"

In addition, Norman, Hanson & DeTroy is proud to announce that sixteen of its attorneys have been named to the 2019 edition of The Best Lawyers in America, the oldest and most respected peer review publication in the legal provision. First published in 1983, Best Lawyers is based on an exhaustive annual peer-review survey comprising of nearly 4 million confidential evaluations by some of the top attorneys in the country. The Best Lawyers list appears regularly in Corporate Counsel Magazine, and is published in collaboration with U. S. News & World Report. The following attorneys were honored by Best Lawyers for their work and expertise in the listed practice areas:

Robert W. Bower, Jr.
Labor Law
Worker's Compensation Law – Employers

Jonathan W. Brogan
Medical Malpractice Law – Defendants
Personal Injury Litigation – Defendants

Paul F. Driscoll
Litigation – Real Estate
Real Estate Law



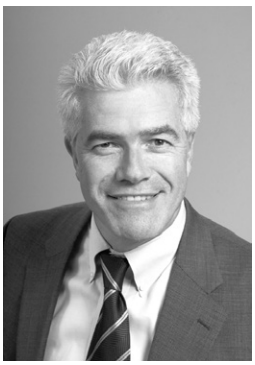
John W. Geismar
Tax Law

David L. Herzer, Jr.
Insurance Law
Personal Injury Litigation – Defendants
Professional Malpractice Law – Defendants

Stephen Hessert
Worker's Compensation Law – Employers

Kelly M. Hoffman
Litigation – Labor and Employment

John H. King, Jr.
Worker's Compensation Law – Employers



Mark G. Lavoie
Medical Malpractice Law – Defendants
Personal Injury Litigation – Defendants

Thomas S. Marjerison
Personal Injury Litigation – Defendants

Stephen W. Moriarty
Worker's Compensation Law – Employers

Russell B. Pierce, Jr.
Appellate Practice, Commercial Litigation, Ethics and Professional Responsibility Law, Product Liability Litigation – Defendants, Professional Malpractice Law – Defendants

James D. Poliquin
Appellate Practice
Bet-the-Company Litigation
Commercial Litigation
Insurance Law
Personal Injury Litigation – Defendants

Daniel P. Riley, Jr.
Administrative/Regulatory Law
Governmental Relations Practice

Roderick R. Rovzar
Corporate Law
Real Estate Law

John R. Veilleux
Insurance Law
Personal Injury Litigation – Defendants

Kelly M. Hoffman's Team USA Experience

As many of you recall from our Winter 2018 newsletter, Kelly Hoffman traveled to Terrassa, Spain in July along with the country's elite field hockey players to represent Team USA in the 2018 FIH Masters World Cup. The biennial tournament took place July 27 through August, and hosted more than 140 national teams competing in five age brackets. Kelly played goalkeeper for her team during six games, two of which were wins over Wales and Italy. Unfortunately, Zimbabwe, Argentina, Spain, and New Zealand proved tough competition for Team USA.

Despite the losses, Kelly's team ranked seventh among teams competing in her age bracket. She returned to Maine in high spirits and is happy to officiate middle and high school games in southern Maine again this fall.

"Surviving cancer as a young adult caused me to assess and reevaluate my life goals. Field hockey has been a passion of mine since high school, and when my collegiate coach told me about U.S. Women's Masters Field Hockey, I jumped at the opportunity to become a part of the league," Kelly says. "Being a part of Team USA has been epic and legendary. It amazes me how good everyone on the team is and how excited we all were to represent USA."

2018 Fall Forum & Client Reception

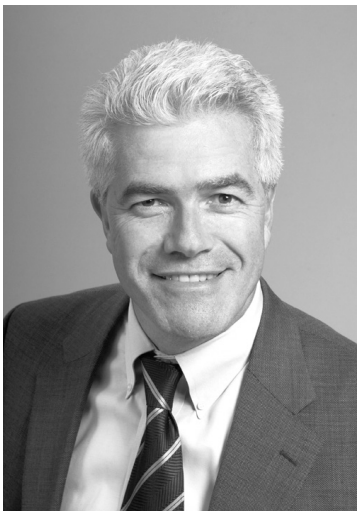
November 16, 2018
Portland Regency Hotel • 20 Milk Street
Fall Forum 2-4
Client Reception 4-7

The forum will be followed by our client reception at the hotel, and we cordially invite all interested clients to join us. Please mark your calendars, and look for your invitation and topic announcements in the mail. ***We hope to see you there!***

2018 New England Super Lawyers and Rising Stars

Norman, Hanson & DeTroy is proud to announce that the 2018 edition of New England Super Lawyers and the 2018 New England Rising Stars has recognized several of our attorneys for inclusion in the publications. We congratulate each of these attorneys for this accomplishment.

Top 100 2018 New England Super Lawyers



Mark G. Lavoie
Personal Injury Med Mal: Defense

2018 New England Super Lawyers

Jonathan W. Brogan
Personal Injury General; Defense

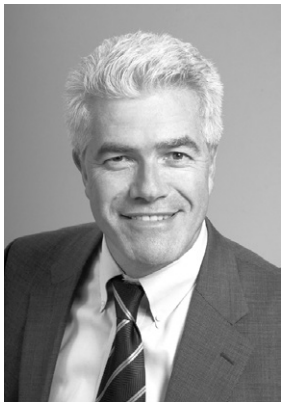
David L. Herzer, Jr.
Construction Litigation

Stephen Hessert
Workers' Compensation

2018 New England Super Lawyers

John H. King, Jr.
Workers' Compensation

Theodore H. Kirchner
Professional Liability: Defense



Mark G. Lavoie
Personal Injury Med Mal: Defense

Thomas S. Marjerison
Personal Injury General: Defense

Russell B. Pierce, Jr.
Civil Litigation: Defense

James D. Poliquin
Insurance Coverage

Jennifer A.W. Rush
Personal Injury Med. Mal: Defense

John R. Veilleux
Personal Injury General: Defense

2018 New England Super Lawyers Rising Stars

Christopher L. Brooks
Creditor Debtor Rights

Devin W. Deane
Civil Litigation: Defense

Joshua D. Hadiaris
General Litigation

Grant J. Henderson
Workers' Compensation

Kelly M. Hoffman
General Litigation

Matthew T. Mehalic
Insurance Coverage

Darya I. Zappia
Business/Corporate

Kudos

Members of NHD's Workers' Compensation Practice Group were active participants in the annual Comp Summit Seminar in August. **STEVE MORIARTY** and **KATLYN DAVIDSON** were presenters in a program tailored for those who are new to the workers' compensation system, and Steve and **LINDSEY SANDS** followed up as panel members reviewing key current issues for those with more substantial experience. Finally, **ELIZABETH BROGAN** was a panel member in the final program titled "Think Tank" addressing issues of importance for the future of the workers' compensation system.

KELLY HOFFMAN, DARYA ZAPPIA, and **DEVIN DEANE** were recognized for their pro bono legal services by the Katahdin Counsel Recognition Program, a program created by the Maine Supreme Judicial Court to focus the public's attention on the critical role that pro bono legal services play in maintaining a vibrant civil justice system.

DAVE HERZER was asked by Bar Counsel and the Executive Director of the Board of Bar Overseers to chair the Professional Ethics Commission for a third consecutive year in 2019.

STEVE HESSERT spoke at the ALFA International Workers' Compensation Seminar in Scottsdale, Arizona on October 4th. His topic was on recent case law developments and claims management techniques in managing Medicare claims for both conditional payments and future medical set asides. Steve will present on the same topic at the Maine Self Insurance Guaranty Association's annual meeting in November.

CHRIS BROOKS recently served as co-chair of the Search Committee for the Interim Head of School at Gould Academy. A 1999 graduate of Gould Academy – a 240 +/- student co-ed private/independent boarding school – Chris has served on its Board of Trustees since 2012 and is a member of the Board's (i. Executive Committee; ii. Audit Committee; and iii. Committee on Trustees & Governance).

As State Chair of the American College of Trial Lawyers, **MARK LAVOIE** and other state committee members organized and welcomed Fellows to a well-attended and successful Northeast Regional Summer Meeting Program in Portland in late June.

DARYA ZAPPIA and her husband Christian welcomed the birth of their second child, Sophia, in July.

Summer 2018 issue

Return Service Requested

Norman, Hanson & DeTroy, LLC
Two Canal Plaza
P.O. Box 4600
Portland, Maine 04112