DCA Meeting – February 7, 2017

CIVIL CASE LAW UPDATES

The Delaware Superior Court declines to dismiss a medical negligence lawsuit against a medical practice which alleged that one of its doctors had a romantic affair with a former patient which later turned into a physician-patient relationship, ultimately resulting in her suicide.

Newborn v. Christiana Psychiatric Services, et al., C.A. No. N16C-05-047 VLM (*Del. Super. Ct.*, January 25, 2017)

Plaintiff's decedent, Lindsay Ballas ("Ballas"), was a former patient of Dr. Jorge A. Pereira-Ogan ("Doctor"), a doctor with Defendant Christiana Psychiatric Services ("CPS"), who subsequently formed a romantic relationship with her. Plaintiff alleged that during this relationship, Doctor provided Ballas with medication and that a physician-patient relationship was formed. Plaintiff alleged that Doctor negligently prescribed Ballas a sample of a medication known as Brintillex, which Ballas took, allegedly causing her to commit suicide. Plaintiff alleged that Doctor was an employee and/or agent of CPS, that the Brintillex samples were obtained from CPS, that CPS knew or should have known of Doctor's actions, and that CPS failed to adequately instruct and/or train Doctor.

CPS moved to dismiss Plaintiff's Complaint for failure to state a claim upon which relief may be granted. CPS argued, relying on documents outside the pleadings consisting of two IRS 1099 forms, Doctor's business license, and Doctor's telephone listing, that Doctor was an independent contractor of CPS rather than an employee. The Court declined to rely on the extrinsic evidence because it was presented to prove the truth of the matter asserted, i.e., that Doctor was an independent contractor.

The Court also rejected CPS's argument that discovery would only determine that Doctor was an independent contractor, finding that a conclusive determination of agency at the pleadings stage would be premature. The Court further declined to dismiss Plaintiff's case on agency grounds, holding that when viewed in the light most favorable to Plaintiffs, the facts alleged involved conduct "squarely within" Doctor's alleged employment, i.e., prescribing medication for a patient with a medical condition. The Court also held that questions of the existence of a physician-patient relationship are normally left to the trier of fact to determine.

Finally, the Court denied CPS's motion to dismiss the direct allegations against CPS, holding that the allegations of agency and negligent supervision raised by Plaintiff were sufficiently pled to withstand dismissal.

The Delaware Superior dismisses a personal injury Complaint filed after the running of the Statute of Limitations, holding that the illness and death of Plaintiffs' former attorney during the pendency of the case did not toll the Statute of Limitations.

McGinnis v. Pierelli, Del. Super., C.A. No. N15C-07-180 FWW (*Del. Super. Ct.*, Jan. 13, 2017)

Plaintiffs were injured in a motor vehicle accident which occurred on May 31, 2013. During the pendency of their claim, they were represented by an attorney ("Attorney") who became severely ill with liver cancer and died July 1, 2015 without filing a Complaint. Plaintiffs alleged that during their representation by Attorney, she was physically and mentally unable to maintain her law practice. Plaintiffs subsequently retained new counsel, who filed suit in Superior Court on July 22, 2015.

Defendant moved to dismiss on the basis that the Complaint was time-barred under the two-year statute of limitations for personal injury matters pursuant to 10 *Del. C.* 8119. Plaintiffs asked the Court to create an exception to the statute of limitations due to Attorney's illness and death. Plaintiffs advised the Court that Attorney first represented them on June 17, 2014 and that during a vacation out of the country between April 2015 and May 6, 2015, Attorney became ill and was transferred to a hospice facility on June 23, 2015 where she remained until her July 1, 2015 death.

The Court rejected Plaintiffs' argument, holding that Section 8119 was "unambiguous" in requiring a personal injury claim to be filed within two years of the injury and contained no exceptions for an attorney's illness or death. The Court declined to create an exception to Section 8119, holding that was within the prerogative of the General Assembly, not the Court. As such, Plaintiffs' Complaint was dismissed as time-barred.

WORKERS' COMPENSATION CASE LAW UPDATE

The Supreme Court addressed whether a claimant's immigration status alone rendered her a *prima facie* displaced worker and concluded that Claimant's undocumented immigration status was not relevant in determining whether she was a *prima facie* displaced worker, but was a relevant factor to be considered in the Board's determination as to whether she was actually displaced.

Roos Foods v. Guardado, 2016 WL 6958703 (Del. Nov, 29, 2016)

Employer filed a Petition to terminate claimant's total disability benefits with the Industrial Accident Board on the basis that the claimant was no longer totally disabled and could return to work. Claimant was an undocumented worker. The Board found that the employer met the initial burden of proving that the claimant was no longer totally disabled, however the Board further found that claimant was a *prima facie* displaced worker based solely on her status as an undocumented worker. In addition, the Board held that employer failed to meet its burden of

showing regular employment opportunities within claimant's work capabilities and denied the employer's petition. Employer appealed Industrial Accident Board's decision.

The Superior Court affirmed the Board's decision and the employer appealed the matter to the Supreme Court. After conducting a thorough analysis of displaced worker status, the Supreme Court reversed and remanded the matter back to the Board for a new Hearing.

The Supreme Court concluded (1) a claimant's status as an undocumented worker does not automatically entitle such claimant to total disability merely because of such status and (2) there is no requirement that a labor market survey used by an employer in a case involving an undocumented worker include testimony from actual employers that such employers would hire undocumented workers.

The Supreme Court recognized that while the Industrial Accident Board's decision might be construed as including a "requirement that employers demonstrate that specific employers exist who hire undocumented workers and have jobs within the claimant's ability that are open, we clarify that no such requirement exists." Rather, the Court stated that "using reliable social sciences methods, there should be no barrier to employers in presenting evidence regarding the prevalence of undocumented workers in certain types of jobs in certain regions and combining that with more specific information about actual jobs in those categories."

Delaware Veterans Home v. Monica Dixon, C.A. No. K15A-12-001 WLW (*Del. Super. Ct.* November 4, 2016)

Superior Court rules that a medical provider, under the Delaware Worker's Compensation Act, is solely responsible for correctly coding their medical treatments for reimbursement under the Delaware Fee Schedule; further, the Board's Decision was too indefinite to be legally sufficient.

Claimant has a long-standing compensable lumbar spine injury which had previously necessitated surgical intervention by the Claimant's spine surgeon ("Provider"). Claimant underwent a subsequent lumbar spine surgery on January 29, 2014. Provider supplied the carrier with the operative report and health insurance claim forms, ostensibly requesting reimbursement for five separate procedure codes related to the compensable surgery. The carrier re-priced two of those codes under the Delaware Healthcare Payment System/Fee Schedule, the latter three codes were denied as being "bundled". Provider requested carrier reevaluate their billing determination, carrier concluded that its payment was appropriate under the Delaware Worker's Compensation Statute and Administrative Regulations.

Claimant filed a DACD Petition before the Industrial Accident Board alleging unpaid medical expenses. The parties agreed that the January 29, 2014 surgery was compensable; the only issue for determination was whether any additional reimbursement was to be paid to Provider. Claimant's case in chief focused on medical testimony with Provider opining as to the reasonableness and necessity of his treatment and a qualitative explanation as to why he selected each of the five billing codes. Carrier presented its medical bill auditor who explained the carrier's

determination that three of those codes were not compensable as they were "bundled" and therefore not payable under the statutorily adopted NCCI billing edits for Medicare.

The Board Decision concluded that Provider had performed a more complex surgery than was ultimately paid by the carrier. The Board instructed the parties to work together to determine the appropriate reimbursement for the medical procedure of January 29, 2014. As a result, the Board granted Claimant's petition.

Employer appealed the Board's determination on numerous grounds. Chief among those arguments was that the medical provider seeking payment for worker's compensation compensable treatment, not the carrier, has an obligation to correctly code their medical treatment for evaluation and re-pricing under the Delaware Fee Schedule. Employer contended that the amendments to the Worker's Compensation Statute (S.B. 1) did not intend to place an onus upon the carrier to maximize provider reimbursement. Similarly, the Employer argued that the appropriate testimony surrounding a billing dispute was not medical expert testimony (as the treatment itself was not contested), but rather whether the billing submissions complied with the statutory requirements. The Court adopted this view and held that the Industrial Accident Board had failed to apply the applicable statutory provisions governing medical expense payment for worker's compensation compensable treatment. Further, the Court held that it is a provider's obligation to correctly code their medical expenses and that the carrier has no obligation to correct or provide alternative billing codes for a provider in order to increase the provider's reimbursement. Lastly, the Court admonished the Board for failing to reach a determination as to the issue that was clearly before it, i.e. whether Provider was entitled to additional reimbursement and held that this instructing the parties to "work together" to resolve the contested issues was an indefinite legal ruling.