An Overview of the Revised 2014 N.C. Medico-Legal Guidelines

The North Carolina Medico-Legal Guidelines were updated in September 2014. The Guidelines, last updated in 2008, and produced by a collaboration of the North Carolina Medical Society (NCMS) and the North Carolina Bar Association, are a key resource for legal practitioners and medical professionals who interact during the course of litigation. Physicians and attorneys have worked together over the years to update this valuable tool, designed to optimize their inter-professional communications, as well as to smooth the sometimes frustrating litigation process for medical providers.

The 2014 Guidelines include significant changes due to applicable laws like the HITECH ACT and address today's technology such as electronic medical records. Having acknowledged that the Guidelines needed to be more user-friendly, they are now published in a magazine-style format, with two columns of text on each page. Key phrases are highlighted and bolded in blue. The updated Guidelines can be found online at http://www.ncmedsoc.org/wp-content/uploads/2014/10/Medico-Legal-Guidelines-PROOF-2.pdf. The following is an overview of the changes in the 2014 Guidelines.

PREAMBLE TO MEDICO-LEGAL GUIDELINES

Physician Complaints

This section has been revised to acknowledge that the Guidelines cannot cover all complaints that physicians may have regarding their interaction with attorneys, and to include physicians' concerns that they sometimes receive inadequate notice of legal proceedings. (p. 3).

Attorney Complaints

This section has also been revised to reflect that the Guidelines cannot address all of the complaints attorneys may have regarding their interactions with physicians. (p. 3).

Scope

Language has been added to include health care providers other than physicians, stating "there is no reason that the Guidelines cannot be considered by attorneys and other health care providers in their interactions with each other." Additional language states that due to continual updates in the law, especially in the area of workers' compensation, all new laws may not be included in this most recent version, and that they are not an "exhaustive recitation of all applicable rules and regulations at any given time." (p. 4).

Professional Liability

In addition to the existing language indicating the Guidelines discuss situations where physicians are not party-defendants, language has been added to indicate that the Guidelines now discuss situations where a physician may be a potential defendant in a professional liability case. (p. 4).

Treating Versus Non-Treating Witnesses

The 2014 Guidelines make an effort to address matters related to "retained medical witnesses" and "fact medical witnesses" and to distinguish between the two types of witnesses where appropriate. (p. 4).

INTRODUCTION

The first paragraph clarifies that "the Guidelines are not intended to and do not expand or limit any obligations of physicians or attorneys under existing federal or state laws or regulations." (p. 5).

A new paragraph addressing medical records has been added, with the first sentence highlighted and bolded in blue, stating that, **"The Guidelines use a definition of 'medical records' that was agreed upon by the North Carolina Medical Society and the North Carolina Bar Association. Other than in the Guidelines, the specific definition likely does not appear elsewhere unless it was borrowed from the Guidelines."** The new language addresses the fact that production of all of the patient's medical records continues to be a source of confusion between physicians and attorneys, and causes problems for both when complete records are not produced in response to a release or subpoena. It discusses the fact that medical records, both in hard copies, electronic forms, and those contained on various machines that now store patient data, can make determining what constitutes the patient's complete medical record very difficult, even with extremely specific requests. Attorneys should be as specific as possible when requesting information, and physicians and their staff should consider all potential sources of patient information when responding to record requests.(p. 5).

SPECIFIC REGULATIONS

The revised first paragraph of the Specific Regulations adds HIPAA and the HITECH Act to the laws, rules, and regulations **that take precedence over the Guidelines.** (p. 6).

DEFINITIONS

This section has been revised to include definitions of new terms: **"Attorney," "Health Information,"** and **"Designated Record Set."** An attorney is a person licensed or otherwise authorized by the N.C. State Bar to practice law in North Carolina. (p. 6). New Footnote 8 states that an attorney should expect any non-attorney personnel working under their provision to follow the Guidelines as well. (p. 7).

Of note, physician assistants are no longer included in the definition of "Physician". (p. 6). New Footnote 7 states that a physician should expect any non-physician practitioners working under their supervision to follow the Guidelines as well. (p. 7).

Health Information means any information, oral or recorded in any form that is:

1. Created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and

2. Relates an individual's past, present, or future physical and mental health or condition; the provision of health care to an individual; and the past, present, or future payment for healthcare of an individual. (p. 6).

A Designated Record Set is:

1. A group of records maintained by or for a covered entity that includes medical or billing records about individuals maintained by or for covered healthcare providers; the enrollment, payment, claims adjudication, and case or medical management records system maintained by or for a health plan; or used by the covered entity to make decisions about individuals; and
2. "Record" within this definition means any item, collection or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity. (p. 6).

The definition of "**Medical Records**" has been revised to add a statement that if they contain information covered by *the prohibitions against redisclosure* found in 42 C.F.R. Part 2 in N.C.G.S. Sections 8-53.3, 53.4, 53.5, 53.7, or 53.8, in N.C.G.S. Chapter 122C, or in any other provision of federal or state law, the physician may produce the balance of the record, *redacting the portion that may not be redisclosed*, along with the statement that "the redacted records may not be released without either patient consent or a court order in accordance with applicable laws and regulations." (p. 6). New footnote 13 in the Definitions section specifies that production of a privilege log or similar document describing the information that is redacted would violate several of these provisions, as a description of the type of medical care sought would itself be confidential. (p. 7).

New footnote 12 cites the N.C. Medical Board "Access to medical records":

> Each licensee has a duty on the request of the patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the licensee believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other licensee offices or healthcare facilities. (p. 7).

New footnote 14 in the Definition section refers to the AMA Code of Medical Ethics Sec. 5.07, "Confidentiality: Computers" and Sec. 5.075 "Confidentiality: Disclosure of Records to Data Collection Companies" and states that N.C. Gen. Stat. §132-1.10(d) *prohibits the inclusion of Social Security numbers or other personal confidential information* by anyone who is preparing or filing a document to be recorded or filed with the court. (p. 7).

SPECIFIC SITUATIONS

MEDICAL RECORDS

The Patient's Right to Seek and Amendment to the Designated Record Set

This new section states that under HIPAA the patient has a right to have a covered entity amend protected health information or a record about the individual in a designated record set *for as long as the protected health information is maintained by the designated record set.* There are several circumstances under which a covered entity can deny an individual's request for amendment: if it determines that the protected health insurance or record was not created by the covered entity, was not part of the designated record set, would not be available for inspection under 45 C.F.R. § 164.524, or is accurate and complete. (p. 8).

INSPECTION AND COPYING OF MEDICAL RECORDS

Required Authorization

Language has been added *allowing a patient to give verbal authorization for the production of medical records.* The physician has the right to request a written request for medical records. The request must be in writing if the patient directs that the medical records be provided to anyone other than the patient. Additional language states that in workers' compensation cases, there is a statutory policy "to protect the employee's right to a confidential physician–patient relationship while allowing the parties to have reasonable access to all relevant medical information, including medical records, reports, and information necessary to the fair and swift administration and resolution of workers compensation claims, while limiting unnecessary communications with and administrative requests to healthcare providers." New footnote 25 to this section specifically addresses HIPAA requirements, indicating that HIPAA permits such disclosure under an exemption per 45 C.F.R. §164.512(l) which allows a covered entity to disclose protected health information to the extent necessary to comply with workers' compensation laws. (p. 8).

What Should be Produced in Response to Appropriate Authorization

This is a new section regarding the inspection and copying of medical records, stating that under HIPAA, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the information is maintained in the designated record set, except for:

1. Psychotherapy notes;
2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and
3. Protected health information maintained by covered entities that is subject to the Clinical Laboratory Improvements Amendments of 1988 , 42 U.S.C. 263a, to the extent the provision of access would be prohibited by law; or exempt from the Clinical Laboratory Improvement Aments of 1988, pursuant to 42 CFR 593.3(a)(s).

In this new subsection, attorneys are encouraged to be specific as possible when requesting medical records. The physician should produce all documents meeting the definition of "medical records" unless a smaller subset of records is requested. (p. 8).

Permissible Charges for Copying Medical Records and Format in which Records are Provided

This section regarding the inspection and copying of medical has been revised to include language stating that in cases other than those involving personal injury liability or Social Security disability, "a reasonable cost-based fee" that includes only the cost of "copying, including the cost of supplies and labor of copying "as well as the cost of postage can be charged if the records are mailed. (p. 9).

New language in this section addresses HIPAA regulations. Under HIPAA, covered entities must produce records in the form requested by the individuals, if the records are readily producible in that form. If the records are maintained electronically and cannot be produced in that form, a copy must be provided in a "readable electronic form" rather than a hard copy. Further, it provides that if the electronic form is requested by the patient, then he should be allowed to receive it by paying *a reasonable fee* associated with reproduction of the records in this format. Under the HITECH Act, the cost cannot exceed the labor and supply costs for producing the electronic health record. (p. 9). New Footnote 31 states that North Carolina currently has no statute setting forth the cost of reproducing records electronically and that the HIPAA standard in 45 CFR § 164.524(c)(4) should apply. (p. 13).

REQUESTING MEDICAL RECORDS OR A MEDICAL REPORT FROM A TREATING PHYSICIAN

Authorization

This section has new language stating that a physician may disclose protected health information of an individual to a family member, or other persons identified by patient prior to his death, who was involved in the individual's care or payment for healthcare prior to the individual's death, if it was relevant to that person's involvement - unless doing so is inconsistent with any prior expressed preference of the individual that is known to the physician. A new sentence that seems to address physician concerns regarding the misuse of subpoenas states a subpoena signed by an attorney, without more, is insufficient to allow a physician to produce any patient medical information. (p. 9).

Promptness

New language, bolded and highlighted in blue, states HIPAA's deadline for health care providers' production of medical records: "HIPAA requires that records be produced within 30 days of a request or within 60 days if the requested records are off-site." (p. 10).

SPECIAL CONSIDERATIONS FOR SUBSTANCE ABUSE DIAGNOSIS AND TREATMENT RECORDS AND FOR PSYCHOTHERAPY NOTES

The introductory paragraph to this section has been modified to reflect that a facility is prohibited from even acknowledging whether an individual is or ever was a patient at the facility absent the patient's

written consent order appropriate court order. (Previously the Guidelines said the facility could not acknowledge the patient's admission at all.) (p. 10).

Substance Abuse Records

Language has been added that clarifies a subpoena alone, even if signed by a judge, is never sufficient to compel disclosure of certain types of these records, and that exemptions exist to the procedures for issuing court orders for these records when reporting child abuse and neglect to appropriate state or local authorities. Additional language at the end of this section states that attorneys seeking court orders to produce substance abuse documents should make sure the order contains appropriate language to allow a physician to disclose such records and be in compliance with 42 CFR Part 2. (p. 10).

Mental Health Records

This section has been revised to read that The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 governs the disclosure of information by physicians at facilities whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers. (p. 10).

Communicable Diseases

This new section requires physicians to keep strictly confidential all information identifying individuals with the AIDS virus infection or certain other communicable diseases. (p. 10).

GUIDANCE TO PHYSICIANS ABOUT CAPACITY OR COMPETENCY

This extensive new section has been added to the Specific Situations - Medical Records portion of the Guidelines. It outlines the questions that physicians may be asked about their patients and the opinions that attorneys may routinely ask physicians to give about their patients, and the standards upon which the physician will be asked to opine. The opinions are:

1. **Opinions of Incompetency for Incompetency Procedures:** This section includes the definition of an "incompetent adult" as a person who lacks sufficient capacity to manage his own affairs or make important decisions about his person, family, or property. The lack of capacity may be due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or similar cause or condition. (p. 11).
2. **Opinions of Capacity/Incapacity to Serve as Fiduciary:** This section discusses the fact that individuals may be appointed to serve as fiduciaries in many roles, including as the personal representative of the decedent's estate, trustees of trusts, agents or attorneys-in-fact under general powers of attorney, or health care agents under health care powers of attorney. Some documents may include provisions for determining the incapacity of a fiduciary. Individuals that are "incompetent adults" as previously defined are not fit to serve as fiduciaries. This section states that the level of capacity for fiduciary should be higher than for an individual simply acting for himself, because of the high level of responsibility and good faith, and the potential consequences to the person or property of others. (p. 11).

3. **Opinions on Testamentary Capacity or Lack Thereof:** This section states that a testator has testamentary capacity if he comprehends the natural objects of his bounty, understands the extent of his property, knows the manner in which he desires his act to take effect, and realizes the effect his act will have upon his estate. The capacity required to revise the revocable trust is the same as the capacity required to make a will. (p. 11).
4. **Opinions on Contractual Capacity or Black Thereof:** This section states that a higher level of mental capacity is necessary to enter into a contract that is required for testamentary capacity. It states that North Carolina courts require that the person be "in such possession of his faculties as to enable him to know at least what he is doing and to contract understandingly." (p. 11).

CONSULTATION AND TESTIMONY

Consultations

New language states the patient's physician and the attorney should agree upfront regarding the physician's charges, if any, for consulting with an attorney during litigation to avoid any later disputes. (p. 11).

Language has been added stating that in workers compensation cases, there may be circumstances under which the employer or its representatives can communicate with physicians. If the physician is in doubt, he should contact the North Carolina Industrial Commission to determine the current status of the law on this issue. (p. 12).

This section still states that a physician has an obligation to consult with the patient's attorney, with the patient's written consent, but adds a sentence stating, "If a patient who has a legal claim requests the physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights." (p. 12).

Physician Deposition Testimony

This section has been revised to state that the physician's deposition should preferably be arranged at a scheduled time and at a convenient place that can reasonably accommodate a deposition. If the physician can provide reasonable accommodations at his office, the attorney should agree to do the deposition there. This language has been bolded and highlighted in blue. (p. 12).

New language explains that depositions are needed for many reasons:

- They are a necessary discovery tool that allows one side of a lawsuit discover the information known to the witnesses for the other side;
- Typically, except at a deposition, the attorney opposing the patient's claim cannot communicate with the patient's physician prior to trial;
- The opposing attorney is frequently in need of the physician's deposition testimony to defend against the patient's claim, and the deposition is usually that attorney's only opportunity to learn the physician's opinion about the patient's medical condition; and

- A deposition may be a preferable alternative to trial testimony when the attorney believes the physician's testimony is of secondary importance. (p. 12).

TRIAL SITUATIONS

SUBPOENAS

Witness Subpoenas

While the language itself has not been changed, the statement, "The trial subpoena itself should be issued as soon as practicable but in no event shall the subpoena be issued later than seven days before trial "has been bolded and highlighted." (p. 15).

Workers' Compensation Cases

This provision has been revised to state that The North Carolina Workers' Compensation Act and Industrial Commission Rules should be consulted regarding the testimony of physicians. The sentence, **"A party to a workers' compensation case must obtain permission from the Industrial Commission before taking and offering the deposition of the medical witness"** has been bolded and highlighted in blue. (p. 15).

NOTICE FOR TRIAL

Medical Witness Availability

This section, previously titled "Fact Expert Witness Availability," states that once an attorney has initially received notice a trial is to be scheduled, they should contact their medical witnesses regarding availability for trial. At that time, each medical witness should let the attorney know the weeks when they are not available to testify. (p. 17).

FACT MEDICAL WITNESSES AND RETAINED MEDICAL WITNESSES

Expert Status

Language has been added that "a retained medical witness will be expected to advocate on behalf of the party who retained them." (p. 17). In addition to the statement that experts have to know more than the jury knows and have an opinion about the subject under inquiry, the statement *"in cases of alleged medical malpractice, more stringent requirements apply"* has been added. (p. 17).

Preparation

A sentence has been added that unless the physician desires to meet elsewhere, *the attorney should go to the physician's office.* (p. 18).

FEES

General Considerations

This section has been modified significantly, with additional language added to encourage the negotiation of fees charged by retained medical witnesses at the beginning of the relationship and prior to the medical witness undertaking any specific task. This provision states that it is accepted practice in North Carolina civil cases that fact medical witnesses are entitled to reasonable compensation for their time spent in conferences, preparation of medical reports, depositions, time spent out of the office for court or other appearances, and for travel costs; and that they may require payment for depositions, conferences and consultations at the time of those services. (p. 18).

The section regarding fact medical witnesses' recommended fees has been revised to state that they may be compensated for time preparing to testify, *even though a successful patient at trial is only allowed to recover the time actually spent a trial testifying from the opposing party.* (p. 18).

A new paragraph has been added to state that an attorney is ethically prohibited from having an economic interest in the client's claim and although the attorney can advance fees to pursue claims, those fees are ultimately the responsibility of the patient/client. (p. 18).

A new paragraph has been added to state that attorneys should not place undue burden on fact medical witnesses for services rendered at the attorney's request on behalf of the patient/client. The following language has been bolded and highlighted in blue:

> No attorney should request the fact medical witness to consult with them or prepare a medical report for them where the client is unable to pay for the same, unless they are willing to advance the cost of such litigation expenses where they have informed the fact medical witness that the client is unable to pay for their services. (p. 18).

The attorney should not request such services if the client is unwilling to pay for them. (p. 18). If prepayment is not feasible, alternate methods of payment must be considered, and the fact medical witness, attorney, and patient may agree to any lawful method of payment. (p. 19).

Fees in Workers' Compensation Cases

This section has been revised to indicate that all expert witness fees, including fees for fact medical witnesses and retained medical witnesses, are subject to approval by the North Carolina industrial Commission. Additional language states that those fees may be limited by the maximum amount set by the Commission. *A 10% penalty fee will be assessed for failure to promptly pay an expert witness following entry of an order to do so.* Medical witnesses and attorneys should agree to the terms of payment, to the extent possible, before obtaining their services in worker's compensation cases.

Fees for Fact Expert Witnesses

This section in the 2008 Guidelines has been deleted in the 2014 Guidelines.

Fees for Retained Medical Witnesses

The section previously titled "Fees for Retained Expert Witnesses" has been re-titled "Fees for Retained Medical Witnesses," with "retained medical witnesses" substituted for "retained expert witnesses."

MEDICO-LEGAL LIAISON COMMITTEE

This section previously titled "N.C. Bar Association Medicaid Legal Liaison Committee" has been re-titled "Medico-Legal Liaison Committee." (p. 21).