# Health Law

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*This chapter reviews the significant judicial, legislative, and administrative law developments of 2012 in the area of health law. This past year, the courts addressed a patient's right to be informed about the availability of diagnostic procedures in certain circumstances, the application of property tax exemptions to nonprofit-owned entities, the collateral source rule in medical malpractice cases, appropriate remedies for collecting payment from Medicaid-eligible patients, and improper disclosures of patient information under state privacy laws.*[1]

*The legislature seemed to focus on issues related to professional licensure: numerous provisions administered by the Department of Safety and Professional Services (DSPS) changed, anesthesiologist assistants are now subject to a new licensing framework, the scope of practice for physician assistants was expanded, and provisions relating to the training of nurse anesthetists were added. The legislature also made significant revisions to the conditions that must be met for a patient to obtain an abortion, revised ambulatory surgical center tax assessment provisions, and expanded the use of electronic prescriptions for schedule II substances.*

*Another big development came from the Pharmacy Examining Board, which implemented a prescription drug monitoring program in the state. The Wisconsin Department of Revenue (DOR) also implemented a new rule governing the process by which a health-care provider may take advantage of the electronic medical records tax credit. Finally, the Board of Nursing revised its regulations to grant itself discretion when considering how and whether a nurse's past disciplinary history in another state might affect his or her endorsement licensure.*

[1] Textual references to the Wisconsin Statutes are indicated as "chapter xxx" or "section xxx.xx," without the designation "of the Wisconsin Statutes." Unless otherwise indicated, in the Statutory Developments section of this chapter, all references to the Wisconsin Statutes are to the 2011–12 Wisconsin Statutes.

## CASE LAW

### *A Physician's Duty to Inform the Patient*

In *Jandre v. Wisconsin Injured Patients & Families Compensation Fund*, 2012 WI 39, 340 Wis. 2d 31, 813 N.W.2d 627, the Wisconsin Supreme Court sided with the plaintiff (a patient), holding that even when a physician has ruled out certain medical conditions, the physician has a duty to inform the patient about diagnostic tests related to those conditions, i.e., tests that the physician is not recommending. This was a closely watched and widely anticipated decision. Amicus briefs submitted by health-care provider groups expressed concern that such a holding would increase the practice of "defensive medicine," i.e., unnecessary treatment rendered simply to avoid risk of liability, and might be confusing to patients, perhaps causing them to overrule the best judgment of their physicians in plotting the course of care.

The underlying facts were not disputed: the patient had stroke-like symptoms and went to the emergency room, where the emergency physician diagnosed the patient with Bell's palsy, a non-life-threatening condition, after considering and rejecting a possible diagnosis of ischemic stroke. The physician listened to the carotid artery with a stethoscope but opted not to do a carotid ultrasound. Eleven days later, the patient had a massive stroke, and the carotid artery was found to be 95% blocked.

The patient brought this medical malpractice action against his physician, the physician's insurance company, and the Wisconsin Injured Patients and Families Compensation Fund. The jury found that the physician was not negligent in reaching the (incorrect) diagnosis of Bell's palsy, but found the physician liable for failure to inform the patient about the carotid ultrasound, which would have revealed the severe arterial blockage. The circuit court entered judgment on the verdict. The defendant appealed, and the court of appeals affirmed.

The arguments before the supreme court centered on whether there should be a bright-line rule that a physician may not be held liable for failure to obtain informed consent when the physician has been deemed not negligent for the care at issue. The defendants argued that (1) if a physician is not negligent in diagnosing a disease, the physician no longer has a duty to inform a patient of alternative diagnostic procedures for conditions unrelated to the condition for which diagnosis was obtained, and (2) absent such a duty, no breach can occur, and a finding of negligence is precluded as a matter of law.

Chief Justice Abrahamson, writing for the majority, rejected the defendant-appellants' proposed bright-line rule and concluded that existing case law and section 448.30 (Wisconsin's informed consent statute) are clear that the physician's duty to inform a patient is distinct from the duty to exercise care in providing treatment. Specifically, the court concluded that the duty of care is measured by the *reasonable physician standard*, *see id.* ¶ 95, while the duty to inform by a *reasonable patient standard*, *see id.* ¶ 96. Thus, satisfaction of one duty does not negate the other. Under the reasonable patient standard, a physician has a duty to "disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis." *Id.* ¶ 199. The supreme court concluded that the jury in *Jandre* properly considered whether the physician's failure to describe the availability of the carotid ultrasound to the patient constituted a breach of this duty, and it affirmed the judgment for the patient.

Justice Prosser, in a concurring opinion noted that the issue should be considered by legislators because the reasonable patient standard may not fit all situations. *See id.* ¶¶ 222–261 (Prosser, J., concurring). Justice Roggensack authored a vigorous dissent, arguing that this decision takes Wisconsin law in an uncharted direction and essentially holds physicians strictly liable for a wrong diagnosis.

- ***Comment.*** As things stand after *Jandre*, physicians must inform patients about diagnostic and treatment options relating to medical conditions that the physician has ruled out if a reasonable person in the patient's shoes would want to know about them in choosing a course of action. This analysis may not always be clear-cut. As a result, many physicians and providers are concerned that *Jandre* will require them to err on the side of providing care and ordering tests that they would otherwise deem unnecessary or inappropriate, to avoid exposure to liability. It is likely that there will be a legislative proposal to revise section 448.30 to clarify the scope of the duty to inform.

***Property Tax Exemptions for Facilities Operated by Nonprofit Entities***

In *Beaver Dam Community Hospitals, Inc. v. City of Beaver Dam*, 2012 WI App 102, 344 Wis. 2d 278, 822 N.W.2d 491 (review denied), the Wisconsin Court of Appeals held that, as an issue of first impression, "benevolent use" is irrelevant to whether a facility owned by a nonprofit entity and licensed under chapter 50 is exempt from property taxes. In this case, a nonprofit hospital system (the hospital) brought an action against the city in which it is located (the city) to recover property taxes the hospital claimed were wrongfully assessed by the city over a two-year period.

The hospital owns a community-based residential facility (the CBRF) that is licensed under chapter 50. The city assessed property taxes on the CBRF in 2009 and 2010, despite the hospital's claim that the CBRF was exempt from such taxes under section 70.11(4)(a). Section 70.11(4)(a) exempts from property taxes "[p]roperty owned and used exclusively by … churches or religious, educational or benevolent associations, *or by a nonprofit entity that is operated as a facility that is licensed, certified, or registered under ch. 50* [of the Wisconsin Statutes], including benevolent nursing homes…." *Id.* ¶ 6 (alteration in original) (quoting Wis. Stat. § 70.11(4)(a)).

The city took the position that property had to be used for a "benevolent" purpose to qualify for tax exemption under the statute. The hospital disagreed, but paid the taxes after the city denied a "Property Tax Exemption Request" filed by the hospital. The hospital then filed a "Claim for Recovery of Unlawful Taxes," which the city also denied, and subsequently filed two lawsuits to recover its payments, one in 2009 and one in 2010. These lawsuits were eventually consolidated before the circuit court, which found in favor of the hospital, and the city appealed to the court of appeals.

The court of appeals agreed with the circuit court, finding that the CBRF qualified for property tax exemption under section 70.11(4)(a). The parties' arguments mainly focused on the "including benevolent nursing homes" clause and its effect on the entirety of the statute. The hospital argued that this clause was merely illustrative and did not require any benevolent use of the property for the statute to apply.

The city, on the other hand, argued that this clause had more than one reasonable interpretation, rendering the statute ambiguous. Such ambiguity would require the court of appeals to construe the statute in favor of taxation. *See id.* ¶ 11; *see also id.* ¶ 25 (citing Wis. Stat. § 70.109 (presumption of taxability)). The city argued that the "including benevolent nursing homes" clause in section 70.11(4)(a) could be interpreted as meaning that "all [c]hapter 50 facilities must be 'benevolent' … to qualify for the exemption." *Id.* ¶ 11. In other words, the city interpreted the clause as "a clause of limitation." *Id.* ¶ 14.

But the court of appeals pointed out that the word "benevolent" only modified the term "nursing homes," and did not modify "facility," the term that the court determined was dispositive to the exemption. Thus, the only condition for the tax exemption of "facilities" owned and used by a nonprofit entity is licensure of the facility under chapter 50.

> ➢ ***Note.*** The court apparently did not consider the alternative interpretation that the chapter 50 licensure requirement for a "facility" applies not to the property being exempted, but to the nonprofit entity that owns the property. This point was moot for purposes of this case because the result would be the same under this alternative interpretation: the property for which exemption is sought would simply not need chapter 50 licensure, but the court's rationale rejecting a "benevolent use" condition would not be affected. Nevertheless, this nuance may be important to interpretations of the statute in different circumstances.

The court of appeals also cited Wisconsin Supreme Court precedent indicating that the word "include" is a term of illustration or inclusion, not exclusion, and thus the "including benevolent nursing homes" clause would not operate as a condition to property tax exemption. *Id.*

Based on this analysis, the court of appeals concluded that the text of the statute was unambiguous, and rejected other arguments put forth by the city based on prior versions of the statute, case law based on such versions, legislative history, the title of the statute, and deference to agency interpretation.

 

***Admission of Collateral Source Evidence Must Be Based on Relevance, but Admission Was Harmless Error in Medical Malpractice Case***

In *Weborg v. Jenny*, 2012 WI 67, 341 Wis. 2d 668, 816 N.W.2d 191, the Wisconsin Supreme Court determined that it was harmless error that a jury in this medical malpractice case heard evidence that one of the plaintiffs (a widow) had received significant life insurance proceeds after her husband's death. The case is significant because the court rejected the defendants' argument that collateral source evidence is always relevant. The court agreed that the circuit court had erred by failing to consider relevance (and affirmed the concept that collateral source evidence is permissible), but that the error did not undermine the court's confidence in the jury's conclusion. This case is significant given the long-standing battle between the plaintiffs' and defense bars as to the proper scope and impact of collateral source evidence in medical malpractice cases.

In *Weborg*, a decedent's survivors brought a medical malpractice action against three physicians for negligently causing the patient's death. The circuit court held in favor of the defendants, but the plaintiffs appealed, arguing that the circuit court improperly admitted evidence of life insurance and Social Security payments received by the widow, which the plaintiffs claimed prejudiced the jury. The court of appeals found this to be harmless error.

The plaintiffs successfully petitioned for review in the supreme court, which affirmed, noting the general rule that evidence cannot be submitted unless it is relevant to the issues at trial. The court also considered the history of collateral source evidence in medical malpractice cases, noting that the Wisconsin Legislature has carved out an exception to the common-law collateral source rule (which states that "an injured party's recovery cannot be reduced by payments or benefits from sources collateral to, or aside from, the tortfeasor," *id.* ¶ 44, and bars evidence relating to such payments) for medical malpractice cases. *Id.* ¶¶ 44–46, 48. Specifically, section 893.55(7) removes the bar to such evidence and expressly permits its admission at trial in medical malpractice cases. *Weborg* is important because it clarifies that evidence must still be relevant to an issue at trial to be admitted.

The plaintiffs argued that collateral source evidence was irrelevant to the issues at trial and therefore should not have been admitted. The circuit court, however, had not considered the issue of relevance, but had simply allowed the evidence to be admitted under section 893.55(7). The supreme court avoided any direct discussion on the relevance of the evidence itself, noting that the circuit court's failure to consider whether the evidence was relevant was harmless error given the particular circumstances of the case.

Chief Justice Abrahamson filed a brief separate opinion, concurring in part and dissenting in part—notably disagreeing as to whether the circuit court's error was harmless. Chief Justice Abrahamson agreed that the circuit court should not have admitted the collateral source evidence. She even went one step further than the majority and declared that such evidence was not relevant to the issues at trial. She argued that the majority understated the import of the collateral source evidence in this case. She emphasized that collateral source evidence can influence a jury's thinking on issues other than damages, so the fact that damages were stipulated and were unaddressed by the jury did not necessarily lead to the conclusion that such evidence had no impact on the case. Because of this, Chief Justice Abrahamson concluded that the circuit court's error was not harmless.

***Enforcing a Lien Against Medicaid-Eligible Patients***

In *Gister v. American Family Mutual Insurance Co.*, 2012 WI 86, 342 Wis. 2d 496, 818 N.W.2d 880, the Wisconsin Supreme Court held that charitable hospitals may assert a lien against personal-injury settlements for the medical care provided to injured Medicaid beneficiaries, and upheld a hospital's lien against a settlement between patients (Medicaid beneficiaries) and a tortfeasor's liability insurance company. The court had to reconcile an apparent disconnect between section 779.80 (which allows charitable hospitals to file liens on personal-injury settlements obtained by patients for the cost of treating the relating injuries) and section 49.49(3m)(a) (which prohibits hospitals from knowingly imposing direct charges on Medicaid recipients in lieu of billing Medicaid). The court concluded that liens filed under the lien statute did not constitute unlawful direct billing of Medicaid beneficiaries, and the court also significantly limited the 1999 holding of *Dorr v. Sacred Heart Hospital*, 228 Wis. 2d 425, 597 N.W.2d 462 (Ct. App. 1999), by concluding that *Dorr* had no application outside its own unique facts.

In *Gister*, three patients had received medical care from the hospital after the patients were involved in an automobile accident. The patients subsequently sued the tortfeasor and the insurer of the tortfeasor's vehicle.

Although the patients were eligible for Medicaid, the hospital declined to bill Medicaid for its services and instead executed a lien on the patients' interests in the suit. After the liens were filed, both parties submitted motions for declaratory judgment (the hospital seeking to have the lien declared valid, and the patients seeking to have the lien declared invalid).

Although no federal cause of action was asserted, the court considered the federal law reflected in Wisconsin's Medicaid plan relating to collection of payments when third parties are liable. Specifically, the court considered 42 U.S.C. § 1396a(25)(C), which prevents hospitals from collecting payment for services from Medicaid-eligible individuals "where third parties are obliged to pay an amount at least equal to the amount that would be paid by Medicaid for the service." *Gister*, 2012 WI 86, ¶ 16, 342 Wis. 2d 496 (quoting *Wesley Health Care Ctr., Inc. v. DeBuono*, 244 F.3d 280, 281 (2d Cir. 2001)). The court noted that the policy behind this prohibition is to prevent "balance billing" and "substitute billing" practices. *See id.* ¶ 24 (explaining that these billing practices occur when a hospital receives less than the desired amount of Medicaid reimbursement and then either attempts to recover the "balance" from the patient or returns the payment and charges the patient as a "substitute" for the Medicaid payment). The court held that this prohibition "is triggered only when a hospital submits a bill to Medicaid," which did not happen here. *Id.* Accordingly, the hospital's lien did not violate federal law or the parallel prohibition in section 49.49(3m)(a).

However, section 49.49(3m)(a) contains a second prohibition beyond the requirements of federal law: A hospital may not "knowingly impose direct charges upon a [patient] in lieu of obtaining payment" from Medicaid. *Id.* ¶ 25 (quoting Wis. Stat. § 49.49(3m)(a)). Unlike the federal provisions, the court noted that state law also applies to situations in which a hospital has not submitted a bill to Medicaid, but bills a patient directly *instead of* billing Medicaid. The court concluded that because the hospital did not bill the patients directly (which would involve sending them a bill, not filing a lien), the hospital did not violate this additional prohibition under state law.

A significant aspect of the *Gister* decision is its limitation of *Dorr*. In *Dorr*, a hospital sought a similar lien against a patient's property interest when that patient was a member of a private health maintenance organization (the HMO) in whose network the hospital participated. In the participation agreement between the hospital and the HMO, the hospital agreed that it would not bill an HMO member directly or indirectly, it would respect certain collections immunities applicable to HMO members by statute, and it would not claim any exemption available under such statutory immunities. When the hospital's lien was challenged, it was held invalid.

The supreme court distinguished *Dorr*, observing that the lien in that case was held invalid on contractual and statutory grounds distinct from the issues in *Gister*. Further, the supreme court noted that the *Dorr* court "was careful not to establish precedent that would be reflexively extended to distinct fact patterns." *Id.* ¶ 44. Based on these observations, the court concluded that *Dorr* was inapplicable to the *Gister* situation and expressly limited the holding in *Dorr* to the facts presented in that case.

***Release of Health-Care Records in Judicial Proceedings for Purposes of Collection***

Wisconsin state law prohibits the disclosure of a patient's medical records without the patient's consent. The rule has exceptions, but in *Ortiz v. Aurora Health Care, Inc. (In re Ortiz)*, 477 B.R. 714 (E.D. Wis. 2012), the U.S. District Court for the Eastern District of Wisconsin limited the scope of one exception, applicable to collection efforts, by using a necessity standard that requires the absence of reasonable alternatives to public disclosure.

Here, five plaintiffs brought an action against Aurora Health Care (Aurora) for unlawfully releasing their health-care records as part of a federal bankruptcy court filing. Each plaintiff was the subject of separate Chapter 13 bankruptcy cases filed in the Eastern District of Wisconsin and had failed to pay for medical services they received from Aurora. Aurora therefore submitted itemized lists of such services to the bankruptcy court as proof of its claims against the plaintiffs, pursuant to Federal Rule of Bankruptcy Procedure 3001. These itemized lists identified the plaintiffs and their medical conditions, and because such filings are public records, any person could freely access this information once Aurora's filings were made.

Based on these filings, each plaintiff brought a claim in the bankruptcy court against Aurora under section 146.82, which prohibits the release of patient health-care records without the patient's consent. Aurora moved for summary judgment, which the bankruptcy court granted, and the matter was appealed to the Seventh Circuit. The Seventh

Circuit determined that the bankruptcy court did not have jurisdiction to render a final judgment here and remanded the case. The bankruptcy court then transferred the case to the district court in a consolidated proceeding.

Aurora's main defense was that an exception under section 146.82 permitted Aurora's release of the medical records to the bankruptcy court because the release was necessary for Aurora to collect or receive payment for services it provided to the plaintiffs. That exception provides, in pertinent part, that "health-care records may be 'released upon request without informed consent … [t]o the extent that the records are needed for billing, collection or payment of claims.'" *Id.* at 723 (quoting Wis. Stat. § 146.82(2)(a)3.). Arguments before the district court focused on how such necessity should be determined and whether it existed in this case.

The district court essentially concluded that a release of health-care records without the patient's consent is not necessary when reasonable alternatives to such release exist. More precisely, the district court found that while Aurora's release of the records to the bankruptcy court may have been necessary, it was not necessary to file the records in a manner that allowed the general public to view sensitive information.

Aurora argued that both the bankruptcy rules and the official form that parties must use to submit proof of their claims (Official Form 10) required Aurora to submit the plaintiffs' health-care records. At the time of the plaintiffs' bankruptcy proceedings, Official Form 10 instructed parties to "[a]ttach copies of supporting documents, such as … invoices [and] itemized statements of running accounts" and to "attach to this proof of claim form copies of documents that show the debtor owes the debt claimed." *Id.* at 723–24. Aurora also argued that, even if the bankruptcy rules and Official Form 10 did not strictly require the release of the plaintiffs' health-care records, section 146.82 still allowed Aurora to release those records for billing and collection purposes.

Based on this evidence, the district court conceded that, in general, Aurora's participation in the bankruptcy proceedings necessitated its submission of the plaintiffs' health-care records to the bankruptcy court. The district court also agreed that section 146.82's necessity standard for releasing records for collection purposes need not be interpreted so as to create unreasonable burdens on a health-care provider.

But the district court pointed to other evidence suggesting that the demands of the bankruptcy rules could be satisfied without making public disclosures, and that the available methods for preserving confidentiality would not have imposed an undue burden on Aurora. When Aurora filed the plaintiffs' health-care records, local procedural rules permitted a party to file documents under seal. A general procedural order also instructed parties to use caution when filing documents containing sensitive information such as medical records and allowed parties to redact such information in their public filings.

As to the burden of taking these steps, "Aurora could have easily released the records to the bankruptcy court and the other litigants without also releasing them to the general public." *Id.* at 726. The fact that Official Form 10 did not expressly describe these options was, in the district court's opinion, immaterial to determining whether the release of health-care records was necessary; it was enough that those options for preserving confidentiality existed. Thus, because reasonable alternatives to full public disclosure of the plaintiffs' health-care records existed, such release was not necessary for Aurora to obtain payment, and the court held that the "billing-and-collection" exception to section 146.28 was inapplicable.

## STATUTORY DEVELOPMENTS

### *Miscellaneous DSPS Provisions*

2011 Wisconsin Act 146 makes the following changes to provisions administered by the DSPS:

1. The act clarifies that members of the Respiratory Care Practitioners Examining Council may serve more than two consecutive three-year terms. Wis. Stat. § 15.407(1m).
2. The position on the Council on Physician Assistants reserved for the vice chancellor for health sciences of the University of Wisconsin–Madison (or a designee) is replaced by a person selected by the Medical Examining Board who teaches physician assistants, and all members of the council now serve four-year terms. Wis. Stat. § 15.407(2).

 

3. A person who is credentialed under chapters 440–480 (which include persons credentialed by boards of nursing, chiropractic, dentistry, medicine, physical therapy, podiatry, dietetics, athletic training, occupational therapy, optometry, pharmacy, veterinary, psychology, nursing home administration, hearing and speech examining, and radiography)
   a. Must report, by first class mail, any felony or misdemeanor conviction to the DSPS within 48 hours after the conviction, Wis. Stat. § 440.03(13)(am); and
   b. May voluntarily surrender the person's license, permit, certificate of certification, or registration, but the issuer of the license, etc., may refuse to accept the surrender if there is a complaint or disciplinary proceeding filed against that person, Wis. Stat. § 440.19.
4. Certain penalties identified in section 440.21(4)(a) and (b) relating to a person's violation of a judicial order obtained by the DSPS are not affected by any provision in chapters 440–480 relating to fines, forfeitures, or imprisonment.
5. To obtain licensure, podiatrists need only one year of postgraduate training if that training was completed by June 1, 2010. Wis. Stat. § 448.63(1)(d)2.

***Purchase and Possession Limits for Controlled Substances***

2011 Wisconsin Act 146 also converts the measuring units used for the limits on the amount of a product containing opium or other schedule V substances that a person can purchase in a 48-hour period without a physician's, dentist's, or veterinarian's authorization. *See* Wis. Stat. § 961.22 (providing controlled substances listed in schedule V). The limit for a product containing opium is changed from 8 ounces to 227 grams, and the limit for a product containing other schedule V substances is changed from 4 ounces to 113 grams. Wis. Stat. § 961.23(5). These limited amounts also apply to a person's possession of such products (other than a physician's, dentist's, or veterinarian's possession of such products). Wis. Stat. § 961.23(7).

***Electronic Prescriptions for Schedule II Controlled Substances***

2011 Wisconsin Act 159 expressly permits electronic prescriptions for schedule II controlled substances. *See* Wis. Stat. § 961.16 (providing controlled substances listed in schedule II). Section 961.38(1r) is amended to clarify that schedule II prescriptions can be written in a hard copy or an electronic format. The act also clarifies that under section 961.38(2), oral prescriptions for schedule II substances must be promptly reduced to a hard copy or electronic format.

***Licensing of Anesthesiologist Assistants***

Before 2012, the state did not have a licensing or certification process for regulating the activities of anesthesiologist assistants to whom anesthesiologists could lawfully delegate tasks. 2011 Wisconsin Act 160 creates such a licensing process.

The act establishes that an anesthesiologist assistant must be licensed to assist and be supervised by anesthesiologists, and cannot hold him or herself out as an anesthesiologist assistant unless he or she is licensed. Wis. Stat. §§ 448.015(1c), (1b), 448.03(1)(d), (2)(e), (k), (3)(g), 448.22(8). Before licensure, anesthesiologist assistants must undergo a criminal background check and take a standardized test. Wis. Stat. §§ 440.03(13)(b)5r., 448.05(6)(a), (ar).

The number of anesthesiologist assistants that an anesthesiologist may supervise is limited by Medicare Part A and Part B regulations. Wis. Stat. § 448.03(7). The act also adds language to sections 448.03(2)(c) and 448.05(1)(d) and creates new sections 448.04(1)(g), 448.05(5w), and 448.13(3), which establish necessary credentials for anesthesiologist assistants, license renewal requirements, criteria for temporary licensure and renewal, and authorization for students to engage in activities that are necessary for their education.

The scope of services that that can be undertaken by an anesthesiologist assistant is also governed by a new section 448.22 created by the act. This section defines the requirements for "supervision" of an anesthesiologist assistant or anesthesiologist assistant student, identifies the types of tasks that can be performed by an anesthesiologist assistant, and restricts the type of entities that may employ anesthesiologist assistants. The section also requires a

"supervision agreement" to govern the assistant's scope of services, establishes various terms that must be addressed in the agreement, and identifies how the agreement must be managed and administered by the parties.

Finally, the act establishes sections 15.407(7) and 448.23, which create a Council of Anesthesiologist Assistants to advise the Medical Examining Board "regarding the scope of anesthesiologist assistant practice and promote the safe and competent practice of anesthesiologist assistants in the delivery of health care services." Wis. Stat. § 448.23. These sections, coupled with certain "nonstatutory provisions" in the act itself, identify the requisite composition of the council, criteria that certain members of the council must meet, and term lengths for which members may serve.

***Supervision of Nurse Anesthetists in Training***

2011 Wisconsin Act 160 also creates a new section 441.11, which prevents an anesthesiologist from supervising more than two nurse anesthetists in training when such trainees are assisting the anesthesiologist. A nurse anesthetist in training may not assist an anesthesiologist without such supervision. This section also clarifies that temporary licenses for anesthesiologist assistants, as discussed above, do not apply to nurse anesthetists.

***Expansion of Permitted Activities by Physician Assistants***

2011 Wisconsin Act 161 expands the type of activities that a physician assistant is authorized to undertake in the following circumstances:

1. The rights of residents of a nursing home or a CBRF to have private and unrestricted communications with certain health-care providers is expanded to communications with physician assistants. Also, the rights of such residents to live in the same room as their spouse or domestic partner, to meet with and participate in activities of social, religious, and community groups, and to be free from chemical and physical restraints, can all be overridden by a physician assistant if such arrangements are medically contraindicated. Wis. Stat. § 50.09(1)(a), (f), (h), (k)).
2. The definition of *home health services* is expanded to include services provided by physician assistants. Wis. Stat. § 50.49(1)(b).
3. A note from a physician assistant certifying a person's illness or disability has the same effect as an equivalent note from a physician in certain circumstances. Wis. Stat. §§ 70.47(8), 118.15(3) (also amended to apply to nurse practitioners and certified advanced nurse practitioners), 252.07(8)(a)2., 252.16(3)(c), 343.16(5)(a)).
4. Physician assistants may disclose a patient's inability to operate a motor vehicle to the Department of Transportation without the patient's consent and may not be held civilly liable either for making such a report or for not making such a report when no such inability exists. Wis. Stat. §§ 146.82(3)(a), 448.03(5)(b)1., 2.
5. An individual who is confined by court order may be released on the opinion of a health officer and a physician assistant that the person is no longer a substantial threat to himself or the public health. Wis. Stat. § 252.07(9)(c).
6. A public health officer or a court may commit a person reasonably suspected of having certain untreated sexually transmitted diseases if the person refuses examination by a physician assistant. Wis. Stat. § 252.11(2), (5).
7. A physician assistant must report to the Department of Health Services (DHS) any patient who ceases or refuses treatment for certain sexually transmitted diseases while the disease is communicable. Wis. Stat. § 252.11(4). Such information is not privileged if the physician assistant is called to testify in a commitment proceeding. Wis. Stat. § 252.11(7). Also, a state laboratory of hygiene examining specimens provided by a physician assistant for a diagnosis of a sexually transmitted disease must report the physician assistant's identity to the DHS if the specimens produce positive results. Wis. Stat. § 252.11(10).
8. Persons who are food handlers must submit to an examination if they have a disease that is communicable through food handling, and this examination may be performed by a physician assistant. Wis. Stat. § 252.18.
9. Physical therapists may treat patients on written referral from a physician assistant and may also treat previously diagnosed conditions if they inform the patient's physician assistant. Wis. Stat. § 448.56(1), (1m)(b).
10. Podiatrists must provide individual charge statements for services rendered independently of other health-care providers, including physician assistants. Wis. Stat. § 448.67(2).
11. The definition of *practice of pharmacy* is amended to include certain services rendered in a hospital and approved by a physician assistant. Wis. Stat. § 450.01(16)(h)3.
12. Communications made to a physician assistant to unlawfully procure a controlled substance are not privileged. Wis. Stat. § 450.11(7)(b).

13. A pharmacist's ability to substitute equivalent drug products when dispensing a prescription in a hospital is not restricted if, in addition to other conditions, the equivalent product's use has been approved by the patient's physician assistant. Wis. Stat. § 450.13(5)(c).

***Ambulatory Surgical Center Tax Assessments Related to Medicaid***

Section 146.98 authorizes the DOR to assess against ambulatory surgical centers (ASCs) a tax that, if compliant with 42 C.F.R. § 433.68, will not reduce the level of federal Medicaid matching funds received by the state. 2011 Wisconsin Act 191 adds a provision to section 146.98 that imposes certain duties on the DOR when the level of federal Medicaid matching funds is nevertheless reduced, possibly because of noncompliance with 42 C.F.R. § 433.68. Wis. Stat. § 146.98(6).

If the DOR assesses a tax against an ASC and federal matching funds related to moneys collected under the tax are not received, the DOR must refund to the ASC an amount equal to the reduction in matching funds and must attempt to recoup the amount of the refund from the federal government. The provision also dictates that all payments made to and from the state under section 146.98(6)(b) must be made to and from the state's Medical Assistance trust fund.

***Provisions Relating to Issues in Procuring an Abortion***

2011 Wisconsin Act 217 adds provisions to section 253.10(3)(b), relating to a patient's consent to abortion procedures. Before the act, section 253.10(3)(b) stated only that a patient's consent to an abortion is not obtained if the patient's consent is coerced. The act adds an additional provision stating that a physician engaged to perform an abortion must determine whether the patient's consent has been coerced and must do so by speaking to the patient outside anyone else's presence (other than persons working for or with the physician). If the physician has reason to suspect that the patient is "in danger of being physically harmed by anyone who is coercing" her to seek an abortion against her will, the physician must "inform the woman of services for victims or individuals at risk of domestic abuse and provide her with private access to a telephone." Wis. Stat. § 253.10(3)(b).

The act also amends section 253.10(3)(d), which describes the family-planning and abortion-related materials that the DHS must develop and distribute and physicians must provide to their patients before an abortion. The act requires that "information on services in the state that are available for victims or individuals at risk of domestic abuse" be added to such materials. Wis. Stat. § 253.10(3)(d)1.

Under prior law, to obtain a patient's informed consent to an abortion, a physician providing an abortion, or another qualified physician, had to provide to the patient the information identified in section 253.10(3)(c)1. The act not only adds to the list of required information, but also specifies that the physician who performs the abortion is the one who must provide this information (except in the case of the third item listed below, when a qualified person assisting the aborting physician, or another qualified physician, may also provide the information). The newly required information is as follows:

1. If the abortion is induced by an abortion-inducing drug, that the woman must return to the abortion facility for a follow-up visit 12 to 18 days after the use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman's medical condition, Wis. Stat. § 253.10(3)(c)1.hm.;
2. That the woman has a right to refuse to consent to an abortion, that her consent is not voluntary if anyone is coercing her to consent to an abortion against her will, and that it is unlawful for the physician to perform or induce the abortion without her voluntary consent, Wis. Stat. § 253.10(3)(c)1.jm.; and
3. That the printed materials described in section 253.10(3)(d) contain information on services available for victims or individuals at risk of domestic abuse, Wis. Stat. § 253.10(3)(c)2.fm.

An *abortion-inducing drug* is a new term defined in section 253.10(2)(am) meaning "a drug, medicine, oral hormonal compound, mixture, or preparation, when it is prescribed to terminate the pregnancy of a woman known to be pregnant." A person will not be liable under section 253.10 for a failure to provide the information in the third item listed above, *see* Wis. Stat. § 253.10(3)(c)2.fm., if the person has made a reasonably diligent effort to obtain those printed materials but the DHS, or a county department of health or social services, has not provided them. Wis. Stat. § 253.10(7).

The act further amends section 253.10(5) to clarify that a woman who seeks or obtains an abortion cannot be assessed a penalty for any violation of section 253.10. Additionally, a new subsection (7m) of section 253.10 states that if a proceeding is brought for a violation of section 253.10, the identity of the woman who sought or obtained an abortion may be kept confidential. On motion to the court or sua sponte, if the court determines that the woman's identity should be kept confidential, the court must order the sealing of all records and exclude unnecessary persons from the courtroom, and provide written findings addressing why confidentiality must be preserved, why the order is essential, how the order is narrowly tailored, and why no reasonable alternatives are available. Any person (other than a public official) who initiates a proceeding for confidentiality under section 253.10(7m) must also use a pseudonym unless the woman who sought an abortion consents to the use of a non-pseudonym in writing. Finally, section 253.10(7m) states that the subsection is not intended to prevent a defendant from knowing the identity of a plaintiff or witness.

2011 Wisconsin Act 217 also creates a new section 253.105. This section states that abortion-inducing drugs cannot be distributed unless the physician who prescribes or provides the abortion-inducing drugs does two things. First, the physician must be present in the room at the time of administration of the drug. Second, the physician must give the woman a physical exam before all information required for informed consent under section 253.10(3)(c)1. is provided. The act also establishes the penalties and civil remedies available for violation of section 253.105, and adopts for section 253.105 the same confidentiality provisions enacted under section 253.10(7m) discussed above. Finally, the act repeals section 940.04(3) and (4), which criminalized a woman's abortion of her "unborn child" or of her "unborn quick child."

As of this writing, issues relating to the statute were being litigated but had not yet been resolved.

***Abortion Coverage by Insurance Plans in State Health Exchanges***

2011 Wisconsin Act 218 prohibits insurance plans that participate in state health insurance exchanges under the federal Patient Protection and Affordable Care Act from covering abortions that are ineligible for funding under section 20.927. Wis. Stat. § 632.8985.

## ADMINISTRATIVE DEVELOPMENTS

***Elimination of the Office of Free Market Health Care***

On January 27, 2011, Governor Scott Walker issued an executive order creating the Office of Free Market Health Care. Wis. Exec. Order No. 10: Relating to the Creation of the Office of Free Market Care (Jan. 27, 2011). The general purpose of this office was to assess the impact on the state of certain provisions in the Patient Protection and Affordable Care Act. On January 18, 2012, Governor Walker issued another executive order dissolving the office. Wis. Exec. Order No. 57: Relating to the Repeal of Executive Order #10 (Jan. 18, 2012). Archives of Wisconsin executive orders are available at http://docs.legis.wisconsin.gov/code/executive_orders.

***Fee for Testing Newborns for Congenital and Metabolic Disorders***

Newborn infants must be screened for congenital and metabolic disorders. The DHS, through the Wisconsin State Laboratory of Hygiene, performs this service for a fee of $109, and had done so before the promulgation of Emergency Rule 1204. 2011 Wisconsin Act 32 required the DHS to issue a rule stating the amount of the fee. *See* Wis. Stat. § 253.13(2). Emergency Rule 1204 has been issued to meet this requirement, although the $109 fee remains the same.

The rule became effective May 4, 2012, and was slated to expire on September 30, 2012. DHS Emer. Rule, Wis. Admin. Reg. No. 677 (May 14, 2012) (creating Wis. Admin. Code § DHS 115.05(3) (creation eff. May 4, 2012)). It received an initial 60-day extension through November 29, 2012, and a second 60-day extension through January 28, 2013. *See* Wis. Admin. Reg. No. 682 (Oct. 14, 2012); Wis. Admin. Reg. No. 684 (Dec. 14, 2012); *see also* Wis. Stat. § 227.24(2) (permitting Joint Committee for Review of Administrative Rules to grant extensions up to a total of 120 days). At the time of writing, it appears that this emergency rule has expired.

***Governor's Council on Physical Fitness and Health***

On June 18, 2012, Governor Walker issued an executive order re-creating the Council on Physical Fitness and Health. Wis. Exec. Order No. 73: Relating to the Re-Creation of the Governor's Council on Physical Fitness and Health (June 18, 2012). The order established the composition of the council and identified its duties as serving in an advisory role to the governor and the public on issues of children's physical fitness, health, and nutrition, and assisting in the prevention of obesity in all Wisconsin residents. The council may have between 9 and 15 members and includes the governor or a designee, the Secretary of the DHS or a designee, and citizen members appointed by the governor.

***Endorsement Licensure of Nurses***

Before the Board of Nursing's adoption of Clearinghouse Rule 12-004, regulatory language granting certain categories of endorsement licenses to nonresident nurses was worded such that any disciplinary action taken against a nurse's license in another state prohibited the granting of a license by endorsement in Wisconsin. Clearinghouse Rule 12-004 amended these provisions to give the Board of Nursing discretion to determine whether a given disciplinary action warranted the denial of a license to the nonresident nurse. Wis. Admin. Code § N 3.03(1)(a)3., (b)6., (2)(a)3., (b)6.

***Electronic Medical Records Tax Credit***

Under Clearinghouse Rule 12-012, the DOR adopted a rule establishing procedures for health-care providers to obtain a tax credit for the purchase and use of electronic medical records (EMR). The rule addresses three areas: certifying eligibility, application for credit, and allocation of credit payments.

Under the rule, *electronic medical record* is defined as an

> electronic record of health-related information that includes patient demographic and clinical health information and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange and integrate electronic health information with and from other sources.

Wis. Admin. Code § Tax 2.985(2)(b).

A health-care provider must certify its eligibility for the credit by providing its license type and number, amounts paid for, description of, federal certification number for, and explanation of how hardware and software are used to maintain EMR, and any other information required by the DOR. Wis. Admin. Code § Tax 2.985(3)(a). *Health care provider* has the same meaning given in section 146.81(1)(a)–(p) of the Wisconsin Statutes. Applications for the credit must be made on a form provided by the DOR and submitted between (1) December 31 of the calendar year in which software and hardware used to maintain EMR was paid for, and (2) January 31 of the following year. Wis. Admin. Code § Tax 2.985(3)(b).

The DOR will grant a combined total of $10 million in credits each year, distributed among the credit applicants. If the total cost of qualified EMR technology purchased by all applicants (the *Total EMR Cost*) is less than $10 million, then each applicant will get a tax credit worth 50% of its calendar year costs for "health information technology software certified pursuant to 45 [C.F.R. pt.] 170 and hardware used to run and access certified software" (the *Applicant EMR Cost*); if the Total EMR Cost is more than $10 million, then each applicant will get a tax credit for a percentage of its Applicant EMR Cost, calculated by the amount of such Applicant EMR Cost proportionate to the Total EMR Cost. Wis. Admin. Code § Tax 2.985(4)(b).

The tax cannot be claimed by a partnership, limited liability company, or tax-option corporation, but the credit can be claimed by the partners, members, or shareholders of those entities in proportion to those persons' ownership interests. Wis. Stat. §§ 71.07(5i), 71.28(5i), 71.47(5i).

 

***Prescription Drug Monitoring Program***

The Wisconsin Pharmacy Examining Board (board) adopted the rule proposed in Clearinghouse Rule 12-009, creating the state's prescription drug monitoring program (PDMP). The provisions of this rule can be found in Wisconsin Administrative Code sections Phar 18.01–18.14.

Under the PDMP, dispensers must record certain information each time they dispense a monitored prescription drug. Wis. Admin. Code § Phar 18.04(2). A *dispenser* is a pharmacy or medical practitioner that is authorized to dispense monitored prescription drugs. Wis. Admin. Code § Phar 18.02(8). A *monitored prescription drug* includes controlled substances under section 450.19(1) of the Wisconsin Statutes and any other drug that the Pharmacy Examining Board identifies as being subject to substantial abuse. Wis. Admin. Code § Phar 18.02(12); *see also* Wis. Admin. Code § Phar 18.03 (drugs that have a substantial potential for abuse).

Information that must be recorded by dispensers includes demographic information about the patient, identifying information about the prescriber and the dispenser, and identifying information and dates for the prescription and its dispensation. Wis. Admin. Code § Phar 18.04(3). Dispensers must file a report containing this information to the board through an electronic database provided by the board within 7 days after dispensing (90 days for veterinary dispensers). Wis. Admin. Code §§ Phar 18.05, Phar 18.06. Even if no dispensation has been made within the last 7 days, a report must be filed attesting to this fact. Corrections must be made in writing to the board within 7 days after discovery of an inaccuracy or omission. Wis. Admin. Code § Phar 18.07.

Certain waivers and exemptions allowing a dispenser to abstain from making the above filings can be obtained for various reasons. Wis. Admin. Code §§ Phar 18.05, Phar 18.06, Phar 18.08. A dispenser can seek review for the denial of a waiver, and the review will proceed according to appeal and procedural rules as adopted by the board. Wis. Admin. Code § Phar 18.10.

A person's authorized access to the PDMP database is governed by the same state and federal legal framework that applies to all other patient health information, of which the regulation specifically identifies sections 146.82 and 450.19 of the Wisconsin Statutes. Wis. Admin. Code § Phar 18.09. The board can revoke a person's access to the database for a variety of reasons, including use of information in violation of state or federal patient-health-information laws; loss of license by the dispenser for any reason; adverse action taken against the dispenser by the board, the state, other states or federal agencies; conviction of a crime "substantially related to the prescribing or dispensing of a monitored prescription drug"; and a delegate's loss of authority from a dispenser. *Id.*

All information in the PDMP database is confidential, and the regulation prescribes the manner in which the board must maintain this information and its confidentiality. *See* Wis. Admin. Code §§ Phar 18.12, Phar 18.13. The board will disclose the minimum amount of PDMP information necessary, subject to all restrictions provided in the PDMP regulations, to the following persons if they create a database account with the board, provide proof of entitlement to the information pursuant to sections 146.82 and 450.19 of the Wisconsin Statutes, as applicable, and make the request through their database account:

1. Designated staff of:
   a. A relevant agency in another state;
   b. A federal or state governmental agency;
   c. The DSPS staff who are charged with investigating dispensing activities;
   d. The Department of Corrections;
   e. A law enforcement authority;
2. Health-care facility staff committee;
3. Accreditation or health-care services review organization;
4. A prisoner's health-care provider, the medical staff of a prison or jail in which a prisoner is confined, the receiving institution intake staff at a prison or jail to which a prisoner is being transferred, or a person designated by a jailer to maintain prisoner medical records;
5. A coroner, deputy coroner, medical examiner or medical examiner's assistant following the death of a patient; and
6. A researcher.

 

Wis. Admin. Code § Phar. 18.11(3)–(10).

The board will also disclose to a patient his or her own PDMP information if the patient appears in person and provides two valid forms of identity and makes a request on the proper form. Wis. Admin. Code § Phar 18.11(1). A person authorized by the patient can also receive the information if the person, in addition to taking the steps a patient must take, provides proof "sufficient to the board" that he or she is so authorized. Wis. Admin. Code § Phar 18.11(2). Finally, the board is authorized to exchange PDMP information with prescription drug monitoring programs in another jurisdiction if that jurisdiction's program is compatible with Wisconsin's PDMP (as defined in the regulation) and if the jurisdiction agrees to exchange information with Wisconsin. Wis. Admin. Code § Phar 18.14.

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