Medical Management and Legal Obligations to Members

Managed Health Care Handbook, 4th Edition Chapter 64 (GH-C134-12)

I Introduction

- medical management activities include use management, quality assurance and dispute resolution programmes
  - a general rule to avoid liability is understand the obligations and act in a reasonable manner

II Obligations to Conduct Medical Management Activities

A. Basis

- must act pursuant to applicable laws, accreditation standards and agreements with customer groups - penalty is increased oversight, loss of license or bankruptcy

B. Health maintenance organizations

- State laws require medical management programmes eg. NAIC Model Health Maintenance Organization Act requires *health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognised standards of medical practice* and grievance procedures
- federal law requires
  - ongoing programme stressing outcomes and peer review
  - effective procedure for collecting, evaluating and reporting use information
- Medicare + Choice requires
  - quality assessment and performance improvement programmes
  - independent review of medical management activities
  - grievance process
- regulatory oversight varies but revocation of license possible

C. Preferred provider organizations

- for preferred provider organizations, NAIC Model Act requires mechanisms to control use and to determine if procedures medically necessary
  - but no quality assurance or grievance procedures
- customers increasingly require accreditation, possibly due to ERISA fiduciary requirements or negligence liability

C. National Committee for Quality Assurance

- one of several accreditors
- most widely accepted
- evaluates compliance with
  - quality management and improvement
  - use management
  - member rights and responsibilities
  - credentialing
  - preventive health service
  - medical records

D. Other standards
- some purchasers specify medical management standard eg Federal Employees Health Benefit Program

III Common Law Medical Management Liability Actions

A. Federal Racketeer Influenced and Corrupt Organizations Act (RICO)
- not preempted by state insurance law
- Pennsylvania class action suit alleged people induced to enroll based on promise of quality care but scheme really based on cost and administration. Dismissed because
  - no actual injuries
  - no actionable fraud claim
  - no conspiracy parent - subsidiary
- problem is potential triple damages

B. Contract actions
- based on contractual obligations not being performed - damages = loss

C. Negligence
- failure to exercise degree of care law requires which results in injury
- damages - compensatory but also punitive possible if action intentional, willful, malicious, wanton, reckless or outrageous

IV Contractual Actions Related to Medical Management Activities

A. Basics
- actions to date generally based on denial of claims or authorisation to provide covered services

B. ERISA preemption
- applies if a state law has a connection with or reference to such a plan under a law which regulates insurance, banking or securities
- not applicable to government, church or non-group benefit plans
- i.e. ERISA only permits enforcement of rights, clarification of rights or enforcement of payment. Hence no damages for breech of contract, pain and suffering, emotional damage or punitive damages.
- provider and patient have option to proceed with medical attention and seek reimbursement - courts and public opinion ignore

1. Pilot Life vs Dedeaux
- ERISA preemption applied as state bad faith law not specifically directed at an insurers= activities

C. Bad Faith Actions

1. Basis

An allegation plan breached its implied duty of good faith and fair dealing when conducting medical management activities - cause of action in 43 states

2. *Gooderick vs Aetna*

- patient had stomach cancer
- 2 procedures suggested by attending physician and each denied 4 months after being made
- third procedure performed without authorization
- jury held against Aetna because of length of delays in denying coverage
- Aetna appealing due to exclusion of evidence
  - wife=s plan had pre-certified treatment
  - coverage exclusion
  - providers not covered and covered providers not sought
  - grievance and appeal procedures not used
  - case management not used

3. Fox

In *Fox vs HealthNet* a patient was denied referral for a breast cancer which had metastasized to her bone marrow. A subsequent bone marrow transplant was also denied. Plan=s oncologist initially recommended referral but changed his mind. Plaintiff=s lawyer alleged:

- certificate provided coverage and oncologist=s initial recommendation showed she met plan=s criteria.
- experimental and investigative procedure exclusion alleged ambiguous since plan subsequently expanded exclusion from one sentence to one page. Also plan=s internal review had found procedures widely accepted and 2 others authorised
- oncologist changed mind after pressure from Medical Director
- the fact the medical director=s bonus based on loss ratio provided an incentive to deny the transplant. (Total bonus to all officers $5.5 million US) Jury awarded $89.3 million. Basic issue was ambiguity as to whether transplants covered. Where coverage for transplants specifically denied, courts have upheld denial of coverage.

1. Effect of promotional materials

- in *Warne vs Lincoln National* certificate clearly excluded transplants but benefit brochure said covered - plan held liable and in bad faith.

2. *Hughes vs Blue Cross of Northern California*

Plan in bad faith because it did not

- conduct a reasonable evaluation
- give physician chance to provide additional information
- balance patient=s interest against cost (critical)

Overturned on appeal as ERISA pre-emption applied

3. Other cases

Bad faith when

- coverage denied as pre-existing before contacting member=s physician
- failure to obtain pertinent parts of medical record
- not requiring medical review before claiming services not medically necessary
- failing to inform members of appeal rights

D. Arbitrary and capricious behaviour

- ERISA does not relieve plan of responsibility to act in a reasonable manner
- if plan has discretionary authority to make benefit decision, courts defer to administrator=s determination unless clearly unreasonable *Jett vs Blue Cross and Blue Shield of Alabama*
- if a substantial conflict of interest, the burden is on the fiduciary to prove its interpretation of plan provisions not tainted by self interest i.e. a wrong but reasonable interpretation is arbitrary and capricious if it advances the interest of the fiduciary at the expense of the beneficiary - *Brown vs Blue Cross and Blue Shield of Alabama*. Another Appeals Court has disagreed and only required plan act reasonably and not be swayed by conflict of interest. Note the fact the plan takes a premium and then pays benefits from <u>its</u> funds creates the conflict of interest
- following held arbitrary and capricious conduct
  - relying on undisclosed medical criteria stricter than other insurers
  - basing an adverse determination on an ambiguous provision
  - failure to comply with notification and reconsideration procedures mandated by ERISA which precluded a member=s appeal

Penalty can be member=s legal fees and costs

V Negligence Actions Related to Medical Management Activities

A. Introduction

- basis is negligence in performing medical management or by provider
- negligent conduct is Aconduct which falls below the standard established by law for the protection of others against unreasonable risk of harm@ i.e. care exercised by a prudent plan in similar cases to avoid causing foreseeable injuries
- damages for
  - lost wages
  - pain and suffering
  - medical expenses
  - other directly caused losses
  - punitive damages if plan acted in a wanton, willful or intentional manner
- unknown if ERISA preempts

B. Negligent Medical Management Activities

1. Denial of treatment

- actions alleging plan negligent when conducting use management activities held preempted by ERISA eg. *Tolton vs American Brodyne* and *Kuhl vs Lincoln National* but reasonable care must be exercised

2. *Wickline vs State of California*

- in dicta, court stated plan may be negligent if physician cannot appeal a non-authorisation decision
- in Wickline, physician did not try to appeal and he was liable as general rule is physician ultimately responsible for treatment decisions

3. *Wilson vs Blue Cross of Southern California*
- court stated plan might be liable even though physician did not appeal denial of authorisation
- case decided on basis non-authorisation did not contribute to death
- appears to erode distinction between physician=s obligation to make medical determinations and plan=s obligations to make benefit determination. Plan could be liable if it is reasonably foreseeable denial will preclude needed covered services

C. Negligence related to the selection and supervision of participating provider

1. Hospital liability

In *Darling vs Charleston Community Memorial Hospital* the hospital held to have a duty to oversee care under licensing regulations, accreditation standards and its by laws

2. *Harrell vs Total Health Care*

Missouri statute immunises non profit health maintenance organizations against liability for negligence. Appellate court stated otherwise - merely determining applicant licensed, could dispense narcotics and had hospital admitting privileges not enough, Failed to conduct personal interviews, check references or conduct further investigations

3. ERISA preemption

- In *Altieri vs Cigna Dental*, preemption held to be effective

D. Negligence actions and incentive compensation

1. Issue

- implementing incentives to limit use is either negligent or a breach of ERISA fiduciary duties

2. *Rush vs Duke* - plan may be liable

1. *Pulvers vs Kaiser Foundation Health Plans*

- incentives recommended by professional organizations and required by Health Maintenance Organization Act

4. Shea vs Esensten

- plaintiff=s alleged plan=s non-disclosure and misrepresentation of incentive arrangement limited patient=s ability to make an informed decision about seeing a cardiologist - a break of fiduciary duty under ERISA
- ERISA preempted state law based claims but breach of fiduciary duty triable

- Appeal Court reasoned plan should have disclosed any material adverse facts

5. Ehlmann vs Kaiser Health Plan of Texas

- Appeal Court held plans not required to disclose incentive arrangements since Act and Regulations do not require disclosure
- distinguished from Shea which had not addressed the statutory interpretation issue. Also plaintiffs had not inquired about arrangements whereas patient Shea had asked to be referred to a specialist.

6. *Herdrich vs Pegram*[1]

- Herdrich alleged medical malpractice and fraud due to wait for tests plus breach of fiduciary duty
- Appeals Court held physicians= plan and employer fiduciaries since they retained discretionary power to decide disputed claims. As fiduciaries, they should act solely in interest of members. Bonus based on controlling use created an incentive to limit use. Hence, an issue for a trial.

7. Effects

- courts believe incentive arrangements create an inherent conflict of interest
- . Failure to disclose is either negligent or creates a breach of fiduciary duty
- 16 states require disclosure as does Medicare + Choice

E. Liability for the negligence of participating providers

1. Basics

- courts split as to whether ERISA preempts plan= s responsibility for malpractice of a participating provider

2. Theories

a. Respondat superior

[1]Author=s Note: US Supreme Court held no breach of fiduciary duty.

Employer controls employees= conduct and responsible for their actions within the scope of their duties

b. Vicarious liability (ostensible agent)
- liable if members believe independent contractor acting as a representative of the plan
- plan liable solely because of its relationship to negligent provider

3. Cases for plaintiffs

a. *Dukes vs Healthcare, Inc*
- since not a claim for benefits nor to clarify right to benefits, ERISA does not preempt

b. *Pacificare vs Burrage*
- claim did not involve administration of the plan and hence law did not relate to plan

c. *Giles vs NYL Care Health Plan*
- courts held 2 types of ERISA preemption
  - complete when seeking to enforce ERISA remedies - tried in federal courts
  - conflict preemption: ERISA provides a defense to state law actions outside of ERISA=s civil enforcement remedies - properly tried in state court

d) *Schleier vs Kaiser Foundation*
- plan liable for malpractice since it
  - restricted access to physician
  - paid physicians to fulfill its service obligations
  - had some right of control over physician=s behaviour

e) *Boyd vs Albert Einstein Medical Center*
- a question of fact whether or not provider plan=s ostensible agent
- based on advertising that provider competent, required use of network, PCP control of referrals, capitation and some control of conduct

4. Cases for defendants

a). *Nealy vs US Healthcare*
- court held ERISA plan created a relationship between plan and Nealy

and malpractice action related to administration of plan - hence preempted
- distinguished between medical management and treatment decision

b) *Williams vs Good Health Plan*
- since Health maintenance organisation cannot practice medicine, not liable
- physician held an independent contractor

F. State and Federal liability laws
- Texas, California and Georgia laws hold plans accountable if negligent in medical management activities

1. Patient Protection Act
- federal
- creates a cause of action if plan negligent when performing medical management activities
- not enacted
- likely results
  - increased premia
  - greater oversight of provider
  - indemnification from providers
  - restrictions on networks
  - plans directly liable if they disagree with provider=s treatment decisions

2. Texas Health Care Liability Act
- model
- MCO must exercise reasonable care when making treatment decisions
- plan proximately liable for treatment decisions of agents, ostensible agents, etc.
- defenses
  - plan does not influence treatment decision
  - plan does not deny or delay payment for any treatment recommended by provider
- plan cannot remove provider for patient advocacy
- plan cannot require providers indemnify plan for their acts
- members must exhaust internal procedures (including external independent review) before going to courts

3. C*orporate Health Insurance Inc. vs the Texas Department of Insurance*

- Federal District Court held liability provisions not preempted by ERISA[2]
- but ERISA preempts
  - prohibition on removing providers for patient advocacy
  - indemnification provision
  - independent review

  because they restrict how MCOs structure their programmes which affect

  ERISA plans which purchase such programmes
- conflicts with Congress= intent to permit uniformity in plans= administration
- Cocoran and Rodriguez cases overruled by Duke=s which distinguished a

  denial of benefits from quality of benefits
- under appeal

VI Recommendations

i) monitor significant court decisions and proposed legislation

ii) update certificates periodically and incorporate specific definitions and specifically explain any exclusion or limitations

iii) ensure marketing brochures accurately describe benefits, exclusions and limitations

iv) ensure medical management issues thoroughly investigated before making adverse benefit determinations eg. have a checklist

v) ensure medical policies consistent with generally accepted standard of medical practice - have a panel review; then distribute to providers - decrease need to deny benefits and hence liability

vi) implement a provider appeal procedure which includes a hearing and provides for expedited review where appropriate

vii) be current on status of new, experimental or investigative procedures or use of centres of excellence (have ability to select providers and patients)

viii) agreements should state plan has discretionary authority to make eligibility and coverage determinations

ix) comply with ERISA=s notice and reconsideration requirements

x) do not make bonus of those making medical management decisions

[2] Because Act created a standard of care while specifically excluding ERISA plans from definition of an MCO.

primarily dependent on plan=s use experience

xi) ensure members have right of appeal of service denials and institute a complaint process with external review

xii) have response times

xiii) issue routed to component individual

xiv) have means to identify and resolve cause

xv) multi-level appeal process to disinterested persons

xvi) require disputes be referred to external agency if not resolved internally

xvii) external decisions - be based on contract provisions and submitted information

- decisions binding unless mistake at law or abuse of discretion

xviii) base provider bonus in part on member satisfaction, compliance and quality of care

xix) refer interpretations of certificates to legal counsel - establishes determination reasonable and in good faith and protect against disclosure

xx) when exceptions made, members should sign an agreement that

- gives reason for exception
- states not a precedent
- prohibits member disclosing contents and existence to third parties

xxi) explain providers independent contractors responsible for all treatment decisions and how their decisions can be appealed

xxii) implement quality assurance - access to services, under-use, complaints - meet accreditation standards

xxiii) adopt credentialing criteria including peer review

xiv) thoroughly investigate questions about a participating provider=s conduct or competence

xxv) terminate providers not complying with medical management requirements

xxvi) do not delegate medical management responsibilities to another entity unless comparable - retain right to audit. Ensure complaints referred

xxvii) purchase professional liability insurance or require providers indemnify the plan for vicarious liability

xxviii) provide/require stop loss coverage where providers at significant financial risk

xxix) furnish members and providers with understandable treatment alternatives information if treatment denied. Require providers to explain.