THOMSON, RHODES & COWIE, P.C. MANAGED CARE LAW UPDATE

Volume II, Issue 1 January 1999

FFDERAL AGENCY ACTIONS

Office of Inspector General (OIG) Will Issue More Guidance on Compliance Programs. To date the OIG has issued four model compliance program guidance papers, tailored for clinical laboratories, hospitals, home health care agencies, and third-party medical billing companies. OIG is currently working on programs for the durable medical equipment, prosthetic and orthotic supply industry, Medicare+Choice organizations with coordinated care plans, and the nursing home industry. The model programs are not mandatory. OIG is currently soliciting comments, suggestions, and recommendations for use in developing its nursing home guidance, specifically concerning risk areas for nursing home facilities and modifications on the seven standard elements (listed below). This comment period ends February 16, 1999, and the guidance is expected to be released this summer. The four published programs incorporate seven basic elements that are borrowed from the federal sentencing guidelines. Future model programs are expected to incorporate these seven elements as well: (1) development of written policies and procedures, (2) designation of a compliance officer and other appropriate bodies, (3) development and implementation of effective education and training programs, (4) development and maintenance of effective lines of communication, (5) enforcement of standards through well-publicized disciplinary guidelines, (6) use of audits and other evaluation techniques to monitor compliance, and (7) development of procedures to respond to detected offenses and to initiate corrective actions.

OIG and HCFA Solicit Comments on Their Proposed Special Bulletin on the Patient Anti-Dumping Statute. The proposed bulletin addresses the principal requirements of the patient anti-dumping statute and how they apply to individuals insured by managed care plans that require pre-authorization for emergency services. The draft bulletin proposes to address: (1) The obligation of hospitals to provide screening to all patients seeking emergency services and stabilizing emergency treatments to individuals seeking such care; (2) special concerns in the provision of emergency care to enrollees of managed care plans; (3) rules governing Medicare and Medicaid managed care plans with respect to prior authorization requirements and payment for emergency services; and (4) types of practices that will serve to promote compliance by hospitals with the patient anti-dumping statute when managed care enrollees seek emergency services. Of particular note is the requirement that hospitals may not delay appropriate screening, examination and stabilizing medical treatment in order to inquire about the individual's method of payment or insurance status, including seeking pre-authorization. The bulletin notes that "Congress has specified that Medicare and Medicaid managed care plans may not require prior authorization for emergency services, and must pay for such services, without regard to whether the hospital providing such services has a contractual relationship with the plan." The obligation of such plans to pay for emergency services is based on a "prudent layperson" standard, meaning that the need for emergency services must be determined from the prospective of a reasonable patient at the time of presentation of the symptoms.

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OTHER JURISDICTIONS (cont'd)

Community Care Behavioral Health Organization (CCBHO) Soon to Take Over Management of Mental Health Benefits for Allegheny County's 140,000 Medicaid Recipients. The transfer will occur by the middle of 1999 in ten counties in Western Pennsylvania. Approximately 10-20 percent of Medicaid recipients receive mental health services, requiring a county-wide budget of $100 million per year. CCBHO will serve as the HMO for all mental health services provided to Medicaid recipients in Allegheny County. CCBHO plans to offer new services such as a mobile crisis team available to go to a patient's home in an emergency, 24 hours a day, seven days a week. CCBHO also hopes to contract with more providers than are currently available to Medicaid recipients and to increase the availability of in-patient care.

OTHER JURISDICTIONS

Denial of Coverage Leads to Big Jury Verdicts. According to recent news reports, a California jury awarded the widow of an HMO member $116 million in punitive damages and $4.5 million in compensatory damages after finding that the HMO committed "malice, oppression and fraud" and thereby contributed to the early death of the member from a rare stomach cancer. The plaintiff sued the HMO, Aetna Healthplans of California, for breach of contract and wrongful death, alleging that Aetna's failure to pay for high-dose chemotherapy was a substantial factor in shortening her husband's life. The HMO has announced plans to appeal the verdict based on the judge's disallowance of evidence supporting Aetna's defense. The verdict is believed to be the largest ever awarded against an HMO.

Humana Ordered to Pay HMO Member $13 Million for Denying Hysterectomy. The plaintiff claimed that her doctor determined that a hysterectomy was medically necessary to cure her cervical cancer. Her contract with Humana promised to cover procedures that the primary care doctor deemed to be medically necessary. At trial the plaintiff presented evidence that a third party independent reviewer, hired by Humana to review requests for services such as plaintiff's hysterectomy, denied approximately 25% of the claims made for hysterectomies during 1994 to 1996, the time period of the plaintiff's request. The jury found that Humana had breached its contract with the plaintiff, and it awarded damages of $13 million. Humana has announced that it will appeal the verdict. Johnson v. Humana Health Plans, Ky. Cir. Ct., No. 96-CI-00462, 10/20/98.

Aetna U.S. HealthCare Inc. Sued for Consumer Fraud Based on the Company's Television Advertisements Concerning the Level of Care Available in its HMO Plans. In the suit filed November 10, 1998, in New York, the plaintiffs claim that the Aetna plan did not offer the benefits that were advertised in the company's television ad. The plaintiffs claim that the ad in question showed a child being airlifted to the Cleveland Clinic, but when the plaintiffs requested treatment for their child at Cleveland Clinic, they were told that the Cleveland Clinic was not an available provider for Members in their area. Aetna responded that the services requested by the plaintiffs were available in New York, much closer to the plaintiffs' home. Maltz v. Aetna U.S. HealthCare, Inc., N.Y. Sup. Ct., No. 605474/98, complaint filed 11/10/98.

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OTHER JURISDICTIONS (cont'd)

An Intermediate Appellate Court in Illinois Produced Mixed Results in Case Involving Claims Against A Medicaid HMO Based on Corporate Negligence, Vicarious Liability, and Breach of Contract. Plaintiff alleged that an HMO doctor failed to schedule an immediate appointment for her infant child, as a result of which the infant suffered brain damage due to meningitis. The appellate court affirmed the lower court's grant of defendant's motion for summary judgment to dismiss the complaints based on corporate negligence and breach of contract, but reinstated the compliant based on ostensible agency. In upholding summary judgment on the corporate negligence claim, the court cited the absence of evidence that the HMO was negligent in credentialing the physician or that the HMO's policies were responsible for the alleged delay. The court noted that although the physician in question had been assigned 4,527 patients by the defendant HMO and 1,500 patients from other HMOs, there was no evidence linking the high number of patients to the physician's alleged negligence in failing to schedule an appointment. Likewise the court found that the HMO did not undertake to provide medical services directly, warranting dismissal of the contract claim. However, the court reinstated the claim based on ostensible agency, finding that the HMO's recruitment and aggressive marketing practices created an issue of fact as to whether the HMO held out the physician as its employee. Jones v. Chicago HMO Limited of Illinois, 1998 WL786614 (Ill. App. 1 Dist.).

Tennessee's TennCare Program has Reduced the Number of Paid Emergency Room Visits by 44% from 1993 to 1996. TennCare, Tennessee's Medicaid managed care program, has ensured that primary care services are available in a less costly outpatient setting in order to reduce the number of unnecessary or preventable emergency room visits. The study determines that the program's measures actually reduced the number of emergency room visits and that a decrease remained even when unpaid emergency room visits were added into the comparison. The text of the study can be found at www.state.tn.us/health/tenncare.

New York Judge Refuses to Dismiss Medical Malpractice Case Against HMO under ERISA or State Law Argument. The defendant HMO provided medical services to its members, including the plaintiff, through its own employees. The plaintiff alleged that an HMO provider failed to properly diagnose and treat her back condition, and failed to advise her against becoming pregnant until it was corrected, which allegedly required her to undergo a discectomy and further surgical procedures. In what has become an increasingly common result in these cases, the trial judge found that ERISA did not preempt the claim because the plaintiff complained of the quality of care provided, not administration of the plan or determination of coverage. The court went on to hold that a state statute providing that an HMO is not involved in the practice of medicine when it provides services directly or indirectly also failed to protect the HMO from this lawsuit. The judge found that the statute did not prohibit all lawsuits against HMOs and did not address the issue of liability when the HMO fails to provide comprehensive health services o causes the patient to be served by unqualified or incapable health care professionals. Blaine v. Community Health Plan, N.Y. Law Journal (Dec. 28, 1998).

Prior issues are available on request. Please direct inquiries to Jerry R. Hogenmiller or L. Jane Charlton, Thomson, Rhodes & Cowie, P.C., Tenth Floor, Two Chatham Center, Pittsburgh, Pennsylvania 15219, (412) 232-3400, TRC_Law@nauticom.net.