Module 10
THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT™ IN MANAGED CARE LITIGATION

I. INTRODUCTION

A. What Is Managed Care?
   1. A comprehensive approach to healthcare delivery that attempts to manage quality, costs, delivery of and access to care.

B. Public Perception

C. Types of Managed Care Organizations (MCOs)
   1. Health maintenance organization (HMO).
      a. Provides healthcare services to a specific group of enrolled persons under a fixed, prepaid plan.
   2. Preferred provider organization (PPO).
      a. An insurance company or group of providers that contracts with providers of healthcare (MDs, nurse practitioners, hospitals) to deliver health services to a group of individuals on a discounted fee-for-service basis.

II. LEGAL THEORIES OF LIABILITY

A. Vicarious Liability
   1. Respondeat superior – An employer is liable for the negligent acts an employee commits within the scope of employment.
a. The law assumes that the employer has the right to control the conduct of an employee. Therefore, the employer is responsible for any negligent acts of the employee while acting within the scope of employment.

b. Under the theory of *respondeat superior*, the MCO is vicariously liable for its employees even if it does nothing wrong.

c. Applies to employees.
   (1) MDs.
   (2) Nurses.
   (3) Physician’s assistants and nurse practitioners.
   (4) Ancillary providers.
   (5) Any employee.

d. Implications for Certified Legal Nurse Consultants®.

2. Ostensible agency.

a. Imposes liability based on the appearance of an agency relationship, even if the relationship does not actually exist.
   (1) Restatement of Torts (second) – Section 429 – definition of ostensible agency: *One who employs an independent contractor to perform services for another, which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services to the same extent as though the employer were supplying them himself or by his servants.*

b. Applies to:
   (1) Physicians who are otherwise recognized as independent contractors, versus employees, including outside specialists.
   (2) Utilization review organization (URO) with which an MCO contracts.
c. The plaintiff must prove two things.
   (1) The patient reasonably believed that an agency relationship existed.
   (2) The MCO’s actions caused the patient to reasonably believe that an agency relationship existed.

3. Imposing vicarious liability on MCOs for the MD’s malpractice strongly encourages MCOs to select physicians with appropriate credentials.

4. Implications for Certified Legal Nurse Consultants (CM).

B. Direct Corporate Liability

1. Introduction.
   a. A corporation is legally responsible for its own corporate actions and its own breach of duty.
   b. The MCO owes a duty of care to the patient separate and apart from the actions of employees and physicians.

2. Negligent acts of the corporation.
   a. Negligent selection, credentialing and retention of physicians.
   b. Negligent monitoring of quality of care and negligent peer review of physicians’ continued competency.
   c. Negligent hiring, supervision and control of employees.
   d. Inadequate policies and procedures; negligent development of standards, guidelines and critical pathways; and failure to enforce and monitor policies and procedures.
e. Inadequate staffing.

f. Inappropriate assignment and delegation.

g. Inadequate education and continuing education of staff.

h. Unsafe and inadequate facilities, equipment and supplies.

i. Negligent utilization review, utilization management, cost containment and negligent monitoring of utilization review (UR) and utilization management processes.

(1) Utilization management is a process intended to monitor quality, contain costs and promote efficiency by keeping to a minimum inappropriate healthcare utilization.

(a) Utilization management includes UR, case management, discharge planning and development of critical pathways.

(2) UR is done prospectively, concurrently and retrospectively.

(a) Prospective utilization review assesses medical necessity in advance of treatment.

(b) Concurrent utilization review evaluates a patient’s need for continued hospitalization and treatment with respect to medical necessity.

(c) Retrospective utilization review assesses whether treatment already provided was medically necessary.

(3) Examples of UR allegations.

(a) Failed to provide for assessment of all necessary information before a UR decision was made.

(b) Failed to provide for a physician in the same specialty to review claims denied.

(c) Failed to have medically acceptable screening criteria and review procedures.

(d) Failed to approve necessary treatment.

(e) Failed to approve transport to a geographically closer hospital when indicated.

(f) Failed to document the rationale for denial of benefits.

(g) Failed to provide an opportunity for the provider ordering the services to discuss the patient’s plan of treatment.

(h) Offered financial incentives as an inducement to reduce or limit medically necessary services.
(i) Failed to inform subscribers of their right to appeal a decision.

(j) Negligently responded to an appeal.

(k) Negligently denied medically necessary care.

(l) Considerations when evaluating a denial of care issue.

(a) What is the purpose of the proposed treatment?

(b) Is the denied treatment considered standard of care or is it experimental?

(c) Is there any proof that the treatment provides benefits and improves outcome?

(d) Do the benefits of treatment outweigh the risks?

(e) Is this treatment cost-effective?

(f) Did lack of access to the treatment adversely affect the patient’s outcome?

(g) Was the treatment recommended by at least one or two physicians?

(h) Is the pathology in question life threatening?

(j) Negligent selection of a utilization management organization.

(k) Negligent misrepresentation.

(l) Negligent structure and operations.

(m) Exerted improper influence on the provider’s judgment through financial incentives or other factors such as peer pressure.

(n) Violated state or federal law.

(o) Negligently failed to provide access to services.

(p) Used inappropriate telephone triage criteria and protocols.

(q) Negligently selected an affiliated healthcare organization.
r. Negligently failed to notify subscribers of members’ rights and responsibilities.

s. Failed to maintain the integrity of the medical records or to set standards for medical records and ensure that standards are met.

3. Direct corporate liability for bad faith denial or delay of care.
   a. The MCO owes an insured a duty of good faith and fair dealing in evaluating claims and making coverage decisions.
   
   b. Allegations.
   
   c. Implications for Certified Legal Nurse Consultants™.

   a. Liable for statements contained in the subscriber contract and for representations made verbally or in brochures.
   
   b. Allegations.
   
   c. Defenses.

5. Breach of warranty.
   a. Based on representations made in subscriber literature, advertising, etc.

6. Fraud by inducement and fraudulent misrepresentation.
7. Tortuous interference with the physician-patient relationship.
   a. The MCO interfering in a contractual relationship between a physician and patient may be liable under the tortuous interference doctrine.

C. Utilization Review Organizations (UROs)

1. UR can be done by an independent URO.

2. Court cases have clearly established that UROs are liable for their actions.

3. URO duties.
   a. Use a standard of medical necessity that is consistent with community medical standards.
   b. Properly investigate the insured’s claims.

4. URO regulation.
   a. Most states have laws regulating UROs.
   b. Voluntary accreditation for UROs is available from URAC at urac.org.
   c. Certification is available from the American Board of Quality Assurance and Utilization Review Physicians, Inc. (ABQAURP) at abqaurp.org.

5. Allegations.
III. LEGAL DEFENSES ASSERTED BY MCOs

A. The Employee Retirement Income Security Act (ERISA)

1. Federal law that applies to employee benefit plans, including health plans.
   a. Employer-sponsored health plans, including managed care plans, are subject to ERISA.

   b. Determining whether a health benefit plan is subject to ERISA requires legal judgment.

2. ERISA provides that a cause of action may be filed to:
   a. Enforce rights to obtain plan information.

   b. Clarify rights to future benefits under a plan.

   c. Recover benefits due or to enforce rights under a plan.

   d. Enjoin an act in violation of ERISA or the plan terms and to redress violations.

   e. Sue for breach of fiduciary duty.

3. A state claim that falls within the scope of ERISA is a federal claim and is under federal jurisdiction. ERISA preempts state laws and state common law claims, such as negligence, relating to employee benefit plans.
   a. The claimant must exhaust administrative remedies before filing a lawsuit.

   b. Trial is by judge versus trial by jury.
c. Recovery is limited to contract damages.
   (1) No recovery for pain and suffering.
   (2) Attorneys’ fees are discretionary.
   (3) Punitive damages and extra-contractual damages are not available under ERISA.

4. Case law suggests that preemption applies when there is denial of benefits, but does not apply in malpractice cases against an MCO that provides care as well as pays for care.

B. Strategic Defenses

1. Preventive measures to reduce vicarious liability.

2. Not medically necessary.

3. The decision to deny payment didn’t cause injuries.

4. Experimental.

5. Exclusion provision applies.

6. The physician’s failure to appeal the benefit denial caused the injuries.
IV. POTENTIAL DEFENDANTS

A. MCOs

B. Physicians and Associate Groups

C. Nurses

D. UROs and UR Nurses and Physicians

E. Affiliated Hospital Facility

F. Other Healthcare Providers

V. ACCREDITATION OF MCOs

A. NCQA

1. Accredits all types of health plans, including HMOs, PPO and POS plans and also provides certification to organizations providing specific medical services.

2. Provides performance measurement via HEDIS.
3. Provides accreditation in the following:
   a. Accountable care organizations (ACO).
   b. Case management (CM).
   c. Disease management (DM).
   d. Health plans (HP).
   e. Managed behavioral healthcare organizations (MBHO).
   f. Medicare advantage (MA).
   g. New health plans (NHP).
   h. Wellness and health promotion (WHP).

4. Provides certification in the following:
   a. Credentials verification organizations (CVO).
   b. Disease management (DM).
   c. Health information products (HIP).
   d. Physician and hospital quality (PHQ).
   e. Utilization management credentialing (UM/C) case management.
5. Publications may be ordered from NCQA.org.


   b. *Standards and Guidelines for the Accountable Care Organizations.*

   c. *Standards and Guidelines for Accreditation in Case Management.*

   d. *Standards and Guidelines for Accreditation and Certification in Disease Management.*

   e. *Standards and Guidelines for the Health Plans.*

   f. *Standards and Guidelines for the Accreditation of MBHOS.*

   g. *Medicate Advantage Module.*

   h. *Standards and Guidelines for the Accreditation of New Health Plans.*

   i. *Standards and Guidelines for Accreditation in Wellness and Health Promotion.*

   j. *Standards and Guidelines for the Certification of Credentials Verification Organizations (CVOs).*

   k. *Standards and Guidelines for Accreditation and Certification in Disease Management.*

   l. *Standards and Guidelines for the Certification of Health Information Products.*
m. *Physician and Hospital Quality (PHQ) Standards and Guidelines.*


**B. URAC**

1. Accredits all types of health plans and organizations including hospitals, HMOs, PPOs, TPAs and provider groups.

2. Provides accreditation in the following MCO-related fields:
   a. Case management.
   b. Disease management.
   c. Health call center.
   d. Health utilization management.
   e. Independent review organization comprehensive.
   f. Independent review organization internal.
   g. Independent review organization external.
   h. Workers’ compensation utilization management.
   i. Claims processing.
   j. Consumer education and support.
k. Credentials verification organization.

l. Health network.

m. Health plan.

n. Medicare advantage health plan.

o. Provider credentialing.

3. Provides certification in the following:
   a. Credentialing support certification program.
   
   b. Vendor certification.

4. Accreditation guides may be ordered from URAC.org.
   a. Case Management Accreditation Guide.
   
   b. Claims Processing Accrediation Guide.
   
   c. Consumer Education and Support Accreditation Guide.
   
   d. Core (Stand Alone) Accreditation Guide.
   
   e. Credentials Verification Organization Accreditation Guide.
   
   f. Disease Management Accreditation Guide.
   
   g. Drug Therapy Management Accreditation Guide.
h. Health Call Center Accreditation Guide.

i. Health Network Accreditation Guide.

j. Health Plan Accreditation Guide.

k. Health Utilization Management Accreditation Guide.

l. Health Web Site Accreditation Guide.

m. HIPAA Privacy (Business Associate) Accreditation Guide.

n. HIPAA Privacy (Covered Entity) Accreditation Guide.

o. HIPAA Security (Business Associate) Accreditation Guide.

p. HIPAA Security (Covered Equity) Accreditation Guide.


r. Medicare Advantage Deeming Program Accreditation Guide.

s. Pharmacy Benefit Management Accreditation Guide.

t. Workers’ Compensation Utilization Management Accreditation Guide.

u. Other standards as developed.
VI. IMPLICATIONS FOR CERTIFIED LEGAL NURSE CONSULTANTS<sup>CM</sup>

VII. CASE EVALUATION WORKSHOP

A. Managed Care Case Study

Mrs. Adams brought her six-month-old son, Joshua, into the HMO clinic complaining of the child’s 102°F fever. The pediatrician diagnosed upper respiratory infection with post-nasal drip. He told Mrs. Adams not to worry about the baby’s fever, prescribed liquid Tylenol, saline nose drops and a vaporizer and sent them home.

At approximately 3:30am, Mrs. Adams awoke and discovered that Joshua had a temperature of 104°F. She had recently given him Tylenol so she called the HMO’s advice line.

According to the HMO’s records, Mrs. Adams told the line operator that the baby was moaning and panting. The operator recognized the seriousness of the call and turned it over to a nurse. Mrs. Adams told the nurse that the baby was limp, not moving and was moaning and panting. The nurse told Mrs. Adams to bathe Joshua in cold water and to await her return call. Mrs. Adams followed the nurse’s instructions. She also called her husband and asked him to come home from work.

The nurse then contacted the on-call pediatrician, advising her of the child’s symptoms. She further communicated to the doctor that she had ruled out respiratory distress. The doctor directed the nurse to tell Mrs. Adams to go to an emergency room that was 42 miles from the Adams’ home. The HMO received a 15% discount for pediatric care from that hospital. The doctor later testified that she was never told about the moaning and panting; otherwise, she would have called Mrs. Adams herself.

The nurse called Mrs. Adams at 4:00am with the instructions to go to the hospital. Mrs. Adams requested directions to the hospital, and the nurse refused, telling her to phone the facility for directions. At 4:30am, the parents departed for the hospital. They passed six other hospitals on their way to the recommended facility.

Joshua had a respiratory arrest 30 minutes into the trip. The family then stopped at the next available hospital ED. The providers at that ED documented that Joshua was unresponsive and in full cardiorespiratory arrest. The ED staff instituted CPR and were successful in obtaining a heart rate and respirations. Joshua was
diagnosed with meningococcemia and hypoperfusion syndrome, which necessitated amputation of both hands and legs.
## Case Study #4 – Case Screening Form

For Internal Use Only – Not to Be Distributed to the Attorney-Client

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Records, Documents, Policies and Procedures and All Tangible Items Essential to a Comprehensive Review of This Case


Specific Sources for Standards of Care or Other Standards Applicable to This Case


Major Topics to Research


Case Theme
Summary of Case


Duty

☐ Yes  ☐ No
If YES, who?


Breach of Duty (Negligence)

☐ Yes  ☐ No
If YES, who?

☐ Healthcare facility  ☐ Other healthcare providers
☐ Corporate owner  ☐ Residents or students in training
☐ Physicians  ☐ Medical or nursing school
☐ Physician’s associate group  ☐ Other negligent parties
☐ Nurses  ☐ Plaintiff
If YES, list negligent parties and summarize deviations from the standards of care (for plaintiff attorneys, do so only if all four elements are satisfied).

- Healthcare facility.
- Corporate owner.
- Physicians.
- Physician’s associate group.
- Nurses.
- Other healthcare providers.
- Residents or students in training.
- Medical or nursing school.
- Other negligent parties.
- Plaintiff.
### Injuries and Damages

**Description**

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Was full recovery achieved?  ☐ Yes  ☐ No

### Causation

Did the negligence cause the injuries complained of?  ☐ Yes  ☐ No

**Causation defenses**

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### Possible Defenses Not Already Addressed Above

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Missing Records or Evidence of Tampering  □ Yes  □ No

If YES, what?

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Problems with the Case for Plaintiff or Defendants

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Potential Expert Witnesses

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Conclusions

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Recommendations