Managed Care Hypothetical Claim Scenarios

OneBeacon HEALTHCARE GROUP

The types of acts, errors or omissions that give rise to managed care errors and omissions (E&O) claims are varied and often result in complex litigation, including class action, anti-trust, and whistle-blower lawsuits alleging regulatory non-compliance and fraud known as qui tam actions. These hypothetical managed care claim scenarios involve allegations of various acts, errors and omissions to help illustrate situations where claims may arise.

Claimants often include, but are not limited to, providers and subscribers/enrollees, and the claims they assert often arise from:

Provider disputes regarding:

- the medical necessity of services provided
- claims adjudication, including whether the amount billed is the "usual and customary" amount
- exclusion from the provider network
- subscriber eligibility verification and preauthorization of services, and

Subscriber disputes regarding:

- utilization review, including medical necessity determinations and delays in preauthorizing referrals, procedures and/or durable medical equipment
- the credentialing process for network providers and vicarious liability for medical negligence
- the number of specialist providers in the provider network
- the advertising and marketing of a health plan
- eligibility for benefits and the enrollment process

Nature of Claim: Subscriber Enrollment/Eligibility

A TPA contracted with a self-funded health plan to perform several functions, including advising employees of their right to obtain continued health insurance benefits through COBRA upon termination of employment. The TPA was responsible for mailing a COBRA packet with information and the required paperwork for COBRA. Six months after termination, a former employee sustained serious injuries after an accidental fall necessitating surgery and prolonged hospitalization. The individual was unemployed and uninsured at the time of the accident. After being sued by the hospital for non-payment of the hospital bill, she sued her former employer, claiming that it was responsible for her hospital bill because she was never advised of her right to obtain coverage under COBRA. The employer subsequently sued the TPA alleging negligence for failure to send out the COBRA packet.

Nature of Claim: Case Management

The insured MCO provided case management services pursuant to a contract with a state Medicaid administrative agency. The state contracted separately with a home health agency to provide homecare services. The MCO and the home health agency had no contractual relationship. Upon making the initial home visit to meet with a frail, elderly enrollee who was receiving home health services three times a week, the MCO's RN Case Manager noted that the individual's apartment was cluttered and presented tripping hazards. The RN Case Manager reported her findings to the patient's physician, notified the home care agency to request a home safety assessment, and scheduled a one-month follow-up case management visit. Two weeks after the initial Case Manager's visit, the home health aide found the patient lying on the floor, unable to get up. She had apparently tripped over a rug, and was subsequently diagnosed with a fractured hip. The individual sued the MCO and its employed RN Case Manager, along with the home health agency, for negligence.

OneBeacon
HEALTHCARE GROUP

OneBeacon Healthcare Group is a brand of OneBeacon Insurance Group that specializes in professional liability coverages and other coverages for physicians and physician groups, free-standing medical facilities, and managed care organizations.

OneBeacon Insurance Group Holdings, Ltd. ("OneBeacon") is a subsidiary of Intact Financial Corporation (TSX: IFC). OneBeacon's underwriting companies offer a range of specialty insurance products sold through independent agencies, regional and national brokers, wholesalers and managing general agencies. Each business is managed by an experienced team of specialty insurance professionals focused on a specific customer group or industry segment, and providing distinct products and tailored coverages and services. OneBeacon's solutions target group accident and health; commercial surety; entertainment; environmental; excess property; financial institutions; financial services; healthcare; management liability; ocean and inland marine; public entities; technology; and tuition refund.

Nature of Claim: Utilization Review

A TPA for a self-insured employer's Health Plan was sued by a hospital in the TPA's network for denial of inpatient benefits. The Plan was contractually obligated to pay for medically necessary care pursuant to the Summary Plan Description of benefits. The TPA performed Utilization Review for the Plan, including precertification and concurrent medical necessity review, pursuant to a contract. The subscriber was admitted to the plaintiff hospital on an urgent basis directly from the physician's office. The hospital called the TPA to "pre-certify" the admission after the subscriber had been admitted. The TPA advised that urgent/emergency admissions are not pre-certified, and confirmed the subscriber's eligibility without further discussion of plan conditions and limitations. The TPA's utilization review nurse monitored the subscriber's stay for medical necessity and deemed continued inpatient days medically necessary. The bill was submitted after the subscriber had been discharged and indicated that the subscriber's condition was directly related to a non-covered cosmetic procedure. The hospital bill was denied by the Plan based on the terms of the subscriber's health plan, which expressly excluded certain procedures it deemed "cosmetic," as well as any complications resulting from those procedures. The hospital sued the TPA, claiming that the TPA represented that the hospital bill would be paid when it was called on the day of admission, and that it relied on that representation to its detriment.

An enrollee experienced severe back pain after lifting a heavy object. The pain continued and he was referred to a neurosurgeon. The neurosurgeon — a participating provider in the patient's MCO network — diagnosed a herniated disc and recommended surgery. The MCO denied authorization for payment of the surgery, basing its decision on lack of medical necessity because the individual had not undergone a trial of physical therapy, a more conservative treatment. Although surgery was finally approved and performed months later, it was unsuccessful. The surgeon opined that too much nerve damage had occurred in the months prior to surgery, and the problem could not be surgically corrected. The patient sued the MCO alleging breach of contract for not authorizing timely care and negligence for wrongly deciding that surgery was not medically necessary.

Nature of Claim: Provider Dispute

A Health Plan terminated its Provider Services Contract with a DME Provider following payment disputes in relation to the Plan's denial of claims because of the Provider's failure to obtain pre-authorization for a certain items/devices as required by the Contract. The Provider subsequently filed a Demand for Arbitration, alleging that the Plan breached its contract by refusing to compensate the Provider for the items/devices it provided.

Nature of Claim: Provider Credentialing

An IPA provides credentialing services for all of its member physicians as required by the health plans with which it contracts, and also performs quality assurance for health plans through physician education programs and by drafting clinical guidelines. A health plan enrollee had emergency surgery, and required a second emergency surgery within 24 hours due to a surgical error that resulted in post-operative complications and sepsis. He sued his surgeon for medical negligence, and sued the health plan and IPA for vicarious liability for the medical negligence, as well as direct negligence in performing credentialing and quality assurance.

These hypothetical claim scenarios are intended for discussion purposes only, and do not in any way establish or otherwise indicate that coverage would be available under any OneBeacon insurance policy for any Claim or potential Claim. OneBeacon reserves all its rights available under its policies and applicable law.

This material is intended as a general description of certain types of insurance coverages and services. Coverages and availability vary by state; exclusions and deductibles may apply. Please refer to the actual policies or consult with your independent insurance advisor for descriptions of coverages, terms and conditions. Some coverage may be written by a surplus lines insurer through a licensed surplus lines broker. Surplus lines insurers do not generally participate in state guaranty funds and insureds are therefore not protected by such funds

Visit onebeaconhc.com for more information or contact Virginia Troy at 860.321.2901 or vtroy@onebeacon.com or Jesica Wardwell at 860.321.2617 or jwardwell@onebeacon.com.

You can also find us on: