By Roger Miyaji, JD

Managed Care Risk Management

Introduction

"Risk Management" describes the business function of identifying and minimizing potential financial losses by purchasing insurance, negotiating contracts, eliminating risks, or reducing damages. All businesses analyze their services or products to determine the main sources (actual and potential) of financial loss, and risk management programs are then developed to address areas of greatest financial exposure. Within health care businesses, risk management programs also improve the quality of care and services while preventing financial losses. Depending on how one views the Kaiser Permanente (KP) Medical Care Program, the greatest financial exposure can result from either 1) potential punitive damages for denial of benefits or 2) professional and general liability claims against physicians or allied health professionals.

Historically, most KP programs have concentrated on professional and general liability claims, but new "managed care" claims have begun to blur the distinction between denial of benefits and professional liability. Managed care claims tend to allege that needed service was denied and that this denial violated the member's health plan agreement and breached community standards of care.

This article explains "managed care liability" and presents some basic components of a risk management program for this liability.

What is Managed Care Liability?

Lawsuits brought by patients against managed care entities fall into two categories: 1) challenges to quality of care or claims of provider malpractice, and 2) assertions that medical treatment was improperly denied. KP has a long history of defending the first type of claim through its Risk Management or Medical Legal departments and defending the second type of claim through its Contract Administration department. Recently, however, these two types of claims have been combined into the same lawsuit, thereby enabling the plaintiff to "dehumanize" the error and thus inflame the sentiments of the jury so that it "sends a message" that such care or treatment will not be tolerated in future cases. If the jurisdiction allows punitive damages, plaintiffs tend to seek these; if punitive damages are not allowed or are severely restricted, plaintiffs tend to use the same argument to increase the amount of the award.

Plaintiff attorneys are increasingly combining regular medical malpractice claims with one or more of the following "managed care" issues:

- negligent selection or supervision of providers
- inconsistent denial of experimental or investigational services (In a 1993 California case the jury awarded $89 million to the plaintiff, a breast cancer patient, after her managed care provider denied payment for bone marrow transplantation. Although the provider based its defense on the plaintiff's contract, which did not cover experimental or investigational procedures, the plaintiff presented evidence that the provider had paid for bone marrow transplantation for another breast cancer patient[1])
- inappropriate delegation to nonphysicians
- nonphysician control of approving emergency services
- misrepresentation/false advertising
- financial incentives which discourage needed services[2]

How to Minimize Managed Care Liability*

The following steps will assist greatly in minimizing managed care liability:

1. Select providers carefully.
2. Provide and document ongoing supervision and evaluation of providers.
3. Establish written criteria for approving or denying experimental or investigational services, and document (with full explanation) any exceptions made.
4. Understanding that supervision by physicians is not an adequate substitute for required licensure, ensure that all nonphysicians are both properly trained and have any applicable licensure. (Some public education about the roles of allied health providers may also be helpful if the providers are relatively new to the locale.)
5. Develop guidelines for advice nurses to use when dealing with potential emergencies, and periodically monitor their telephone conversations with patients (giving all appropriate indications of monitoring or taping required by state law).
6. Legal counsel or legally trained assistants should review all advertising and marketing materials (which should avoid generally subjective qualitative terms such as "best care" or "highest quality").

What Individual Physicians or Allied Health Providers Can Do*

1. Review prior care. Because managed care organizations are large and complex, continuity of care can become a problem. At every patient visit, there-

ROGER MIYAJI, JD, was formerly Counsel and Director of Medical Legal for the Northwest Division. He has developed risk management data systems for the Northwest Division and the Hawaii Region.

fore, review the care given by previous providers (for example, try to review the last three or four notes) to prevent errors caused by inadequate continuity of care. Write an accurate, objective description for the provider who next sees the patient.

2. Offer or recommend preventive care. Recommend appropriate preventive care (e.g., mammography, Pap smears, chest x-ray film, sigmoidoscopy, immunizations, cholesterol screening) based on the patient's risk factors, especially where these are included in marketing materials. Document your recommendations. The duty to offer treatment is as important as the treatment itself.

3. Make extra effort in urgent situations. Always assess the urgency of your requests for diagnostic studies, referrals, or consultations, and never allow scheduling delays to cause excessive risk to the patient. Be sure to document your extra efforts. Avoid the "I just work here" attitude!

4. Provide adequate supervision. Do not allow nonphysicians to practice beyond the scope of their licensure and competence. Similarly, do not allow medical or surgical residents to practice beyond their current level of training and competence.

5. Recommend needed care without regard to coverage. Do not allow specific health plan coverage limitations to prevent giving a patient appropriate recommendations for medical care, and always document such recommendations. Remember: your duty as a physician or allied health provider is to recommend—not to approve—treatment.

6. Communicate fully, with thorough documentation.
   - Provide adequate and accurate information to utilization management (or other persons who approve coverage) to support appropriate decisions.
   - Consider the risk of decisions which deny care to the patient, and objectively explain the reasoning to the patient. Be sure to document this reasoning.
   - When talking to patients or documenting in the records, do not accuse the health plan of denying proper medical care or for offering only a limited choice of referral providers; you may be unaware of other viable options, and the patient may not have exhausted appeals rights.

7. Understand the proper use of telephone advice and follow-up.
   - Because adequate assessment over the phone is often impossible, telephone advice should aim not to restrict care but instead to direct patients to appropriate sources of treatment.
   - When the appropriate medical advice is that no medical appointment or visit to the emergency department is needed, be sure to document both the caller's response (in quotes) and the advice given. Advice to stay home or to call back if the condition worsens should be based on written protocol, and documentation should refer to this protocol.
   - If you either agree to call the patient back or indicate that someone else will call back, ensure that the return call was made and is documented.

8. Use caution when providing informal employee consultations. Employees are health plan members; accordingly, when employees ask for informal medical advice, insist that they schedule an appointment or obtain urgent care. Document employee requests for informal medical advice in the medical records or use forms as specified in your local or divisional policies and procedures.

9. Keep patient/attorney letters within their proper scope. When writing letters to a patient or the patient's attorney, restrict your comments to objective information from the medical records or your own medical observations; do not try to explain health plan coverage unless you have first obtained legal review or assistance from the appropriate health plan representative.

Responding to Patients' Demands for Specialty Referrals*

Most specialty referrals or diagnostic studies are arranged using preapproved protocols or guidelines. The following suggestions can be helpful in addressing what you perceive to be an unreasonable demand. If your area or division has no protocols or guidelines pertaining to this situation, contact the appropriate people about developing such protocols or guidelines.

What To Do

- Take the demand seriously; do not simply dismiss it as foolish. Assure the patient that you understand the reason for his or her concern.
- Explain that the specialist (or radiologist or laboratory) expects certain things to be done before a referral is made or a request for diagnostic studies granted. Never say, "The health plan expects ... "
- Explain your plan by telling the patient, "This is what we need to do before any referral/request is made"; or "If we have not accomplished [goal] by [target date], then I will make the referral (or grant the request)."
- Document your promise. The patient will remember exactly what you said.

What Not To Do

- Never tell patients that the referral or test they have requested is too expensive or that "If I refer every patient who wants to see a specialist, the health system will go broke."
- Never dismiss patients' requests by saying, "I will be the judge of what you need."
- Never say, "Don't worry about it now—if you really need a referral/test, we'll do it another time." This shows a lack of concern.
- Never accuse the patient of being a hypochondriac.
- Never disparage or otherwise attack the patient's lawyer who suggested that the patient seek referral to a specialist. You may explain that tests or referrals are covered only if done for medical reasons and not if done solely for purposes of litigation.

The "Golden Rules"

Although liability and litigation has changed over the years, some things remain the same. It is still as true now as it was 10 years ago that avoiding lawsuits can be as simple or as complex as doing the following:

1. treating your patients as you would wish to be treated if you were the patient;
2. carefully providing documentation that is
   - objective
   - comprehensive
   - legible
   - nothing you would be ashamed of if the written record is enlarged photographically for scrutiny by a jury;
3. Refraining from blaming someone else (especially the health plan) for the patient's condition or outcome.

Clinicians who take these approaches can simultaneously improve quality of service and care given to our members and prevent the financial losses which can result from liability claims. ❖

**Materials adapted from presentation by Dan Tennenhouse, MD, JD, Consultant, Medical Legal Department, Kaiser Permanente, California Division, 1996.*

References
1. Fox v. Health Net, Civ. No. 21962, Riverside County Super. Ct., Cal., Dec. 28, 1993.
2. Gross v. Prudential Health Care Plan, No. CJ-9474267 (Okla. Cty. Ct. Oct. 1, 1996), a trial court decision reported in the "Health Law Digest, 1997, v. 25, n. 1, p. 54 under Managed Care.

"Everyone spoke of information overload, but what there was in fact was a non-information overload."
Richard Saul Wurman, What-If, Could-Be, Philadelphia, 1976.