

AT RISK



A risk management publication written by the members of the North Carolina Chapter of the American Society for Healthcare Risk Management

Message From The President

BUDGET. There's a word that strikes a chord of dread in the heart of nearly every risk management/ quality professional. Maybe even a touch of nausea. Developing a budget and trying to operate within its confines has become an amazing juggling act in an era of down("right")-sizing and shrinking resources.

Even as we struggle to keep our heads above the water, (and maintain our sanity), it's vitally important that we remember the value of continuing education and professional development. Well, you are in luck, because not only are these two of the basic tenets of the North Carolina Chapter of ASHRM, but they are high priority goals of ASHRM as well. Now, I realize that membership in professional organizations is a personal expense for a lot of our members, but this only underscores the importance of belonging to an organization that provides valuable education as well as opportunities for developing a professional network.

Unfortunately, more and more often Risk Management is looked upon by Finance as an expense, and we are forced to work even harder to prove our worth to the organization. To use one of their buzzwords, what is the "value-added" of our function? That's where NC ASHRM and National ASHRM can help by bringing you educational programs and professional development opportunities to grow your knowledge base and keep you updated on the quickly changing insurance market.

I consider it an investment, and I hope that you find that the programs brought to you by NC ASHRM not only meet your professional needs, but also aid you in demonstrating the value that the risk management function brings to the organization.

Douglas J. Borg, ARM, CPHRM
President, NC ASHRM

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OSTENSIBLE AGENCY: ARE YOU PREPARED FOR THIS EXPOSURE? Case #1

Jane Malanowski had been a regular patient of Dr. Reena Jabamoni since 1982. Dr. Jabamoni practiced at the Loyola University Mulcahy Outpatient Center and was also a professor at Loyola University's Stritch College of Medicine. Dr. Jabamoni was not an employee of the outpatient center, but she had very close ties to the center. The outpatient center referred Ms. Malanowski to Dr. Jabamoni, Ms. Malanowski had been treated by other physicians at the outpatient center, and payment for services provided by Dr. Jabamoni was made directly to the outpatient center. The outpatient center was clearly tied to Loyola University because the center bore the "Loyola" name, the administrators and managers of the facility were employees of Loyola, and the outpatient center held itself out as a direct provider of health care services. In 1991 Dr. Jabamoni examined Ms. Malanowski for suspicious lumps in her breasts, which Dr. Jabamoni thought were not clinically significant. Ms. Malanowski died of breast cancer in 1993 after having undergone a radical mastectomy.¹

Case #2

Mindy Goldberg came under the care of Dr. Neil Isdaner when she became pregnant with twins. She and her husband questioned Dr. Isdaner about his ability to handle multiple births. Dr. Isdaner assured them that he was competent to do so. He informed the couple that Mrs. Goldberg would deliver at Jeanes Hospital, and provided them with a brochure about the maternity program at Jeanes Hospital entitled "We Believe in Great Beginnings: The Maternity Suite at Jeanes." The brochure also identified Dr. Isdaner as a member of

HIPAA- Enforcement and Insurance Coverage Issues

By now everyone who is the least bit interested in the subject has heard just about all they care to about HIPAA. This extraordinarily far-reaching and comprehensive new set of federal regulations governing the use and transmission of “individually identifiable health information” became effective April 14,2001. As ASHRM members know all too well, the deadline for compliance was April 14 of this year.

Now that the compliance programs are in place and the business associate agreements are all signed and tucked back into the file, what next? What were the huge outlays of time, effort, consultant’s and attorney’s fees for? The primary motivation was, of course, to protect the privacy rights of patients. From the perspective of the “covered entities” (i.e. healthcare providers, health plans, insurance companies, HMO’s, billing services, etc.) a secondary, but significant, motivating factor for HIPAA compliance are the substantial civil and criminal penalties that may be levied against those individuals and/or institutions deemed to have violated HIPAA’s privacy mandates.

HIPAA Enforcement and Penalties

HIPAA provides for rather severe civil and criminal penalties for those who violate the new privacy regulations. Civil fines of \$100 per violation up to a cap of \$25,000 (in the same calendar year) may be levied by the Department of Health and Human Services (“HHS”). For those found to have “knowingly or intentionally” misused protected health information, criminal fines of up to \$250,000 or up to 10 years in prison may be imposed.

Clearly, the HIPAA stakes are high. Will the “HIPAA police” be knocking on your door to conduct an audit any time soon? Thankfully, the answer is “no.” HIPAA enforcement, as the statute is currently written, is “complaint driven.” That is to say, investigations of alleged violations of HIPAA will be prompted by patient complaints. The federal agency charged with enforcing HIPAA’s privacy regulations is the HHS’s Office for Civil Rights. In a recent interview with *Lawyer’s Weekly USA*, Richard Campanelli, Director for Civil Rights at HHS, said that since the April 14 2003 effective date, his office has received approximately 1,300 complaints. The majority of these complaints, says Campanelli, are from individuals with “a few” coming from attorneys on behalf of their clients. Noting that many of these complaints are summarily disposed of, Campanelli stated that his office has yet to pursue sanctions against any alleged HIPAA violator.

Looking for HIPAA Coverage

That no violations meriting sanctions have been identified in the first five months post-HIPAA is comforting. But what if your institution is notified that the Office of Civil Rights has concluded that a violation has occurred? After conferring with counsel, you should look to your insurance program to see if defense, and possibly even indemnity coverage, is available for HIPAA violations.

When looking for coverage you should bear in mind that policies will respond differently depending upon the type of coverage afforded. None of the policies typically in place for healthcare providers is going to provide coverage for criminal behavior and associated penalties. Therefore, if “knowing” or “intentional” wrongdoing with resulting criminal prosecution is at issue, there is little hope of finding coverage (though some Directors and Officers liability policies do provide defense cost coverage for criminal investigations until there is an

adjudication, or admission, of liability as to the insured). If civil wrongs (i.e. “negligence” or “gross negligence”) are alleged, there may well be coverage depending upon your specific policy language and the nature of the violation alleged. Your review should include the following coverages:

Director’s and Officer’s Liability: Your D&O policy may respond, but you have to look carefully. D&O policies are not at all uniform and the coverage afforded varies widely from carrier to carrier. Given the current instability in the D&O market, nearly all carriers are imposing significant new limitations on coverage. Some are adding “Regulatory Claims Exclusions” that explicitly exclude coverage for “acts errors or omissions in violation of HIPAA.” Other D&O policies are silent as to HIPAA and may provide at least defense costs coverage. In addition to looking at the “Exclusions” section of the policy, the policy definitions of “Claim” and “Loss” should be reviewed as well to determine if statutory fines and/or penalties are covered.

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Physician and Surgeon Professional Liability (medical malpractice): Individual physician policies written on an “admitted” basis (i.e. not a surplus lines policy) likely will provide coverage for HIPAA violations alleged against the insured. Many of these policies explicitly provide HIPAA coverage as an ancillary coverage for the benefit of the individual physician(s) insured (versus the medical practice). Some policies may offer a sub-limit rather than full policy limits, or provide coverage on a defense cost only basis.

General Liability: General Liability policies often exclude statutory fines and/or penalties. However, the “Personal and Advertising Injury” coverage in GL policies generally does include coverage for “invasion of privacy.” This coverage has historically applied to state common law privacy claims (as opposed to the federal statutory liability created by HIPAA). Therefore, the GL policy may be a valuable source of coverage if a claimant alleges general violations of “privacy rights.” Your specific policy language regarding exclusions should be carefully reviewed along with the GL policy definitions of “Damages” and “Loss.” Importantly, HIPAA does not confer upon individuals a “private right of action” (i.e. the right to bring an individual lawsuit alleging damages from a HIPAA violation).

Fiduciary Liability: These policies protect those individuals acting in a fiduciary capacity with respect to the governance of employee benefit and welfare plans. These policies typically do afford some coverage for such fiduciaries for alleged HIPAA violations. Costs associated with declaratory or injunctive relief (as opposed to traditional monetary damages) are often excluded in fiduciary liability policies. The extent of the coverage provided by fiduciary liability policies varies so a careful reading of these policies, as always, is essential.

Employment Practices Liability: EPL policies are, at best, a secondary source of coverage. Of course, the alleged HIPAA violation would have to involve an employee for the coverage to apply. Employment related privacy violations are typically covered by a good EPL policy. Therefore, if the claim involves an employee, your EPL policy should be reviewed for coverage.

Conclusion

The relative likelihood of your institution having to defend a HIPAA-related enforcement action in the immediate future appears small. It is certainly possible, however, that as privacy concerns of the public grow, your hospital will at some point have to defend itself against alleged HIPAA violations. Such claims might very well be joined with state statutory and common law privacy claims. Should this occur, working closely with your broker or agent to determine what coverage exists and where to find it will be essential.

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Jeanes’ “team of physicians.” Dr. Isdaner’s office was located on the campus of Jeanes. Ms. Goldberg went into pre-term labor, which was allegedly handled poorly. One twin died shortly after birth and the other was severely brain damaged. The total award at trial was \$7,273,000.²

Suit was brought against the physicians involved in the care of these patients, but was also brought against Loyola in the first case and against Jeanes Hospital in the second case. Neither physician was employed by either of the hospitals, although they were members of the hospitals’ medical staffs. The issue before the courts was whether the hospitals could be held vicariously liable for the actions of the physicians in the absence of an employment relationship. Both courts, as have a steadily increasing number of other courts around the country, held that the hospitals could be liable in these cases. The question at this time is: how far will this trend go?

Vicarious liability is normally imposed when a court finds that someone is acting, in some manner, as the agent of a principal (the hospital in these cases). The most common theory is that someone was the hospital’s ostensible agent. The test for whether someone is acting as an ostensible agent varies somewhat from state to state, but the test used by the court in the *Malanowski* case is typical of the formulation normally used. This consists of three elements, all of which the plaintiff must show, as follows: (1) the hospital or its alleged agent acted in a manner that would lead a reasonable person to conclude that the alleged tortfeasor was the employee or agent of the hospital; (2) where the acts of the alleged agent created the appearance of authority, that the hospital had knowledge of and acquiesced in such acts; and (3) that the plaintiff justifiably relied upon the conduct of the hospital or alleged agent. Of the three elements, courts commonly neglect the third

element and assume reliance based on the actions of the plaintiff in seeking the care.

The cases discussed above are not typical of the ostensible agency cases commonly seen that can impose vicarious liability on hospitals. The more common variety involves specific classes of physicians that are provided by the hospital. These commonly involve emergency physicians, radiologists, anesthesiologists and pathologists. These physicians are not normally chosen by patients, nor are patients normally given a choice from among these practitioners. Courts in many jurisdictions are imposing liability on hospitals for the actions of these practitioners.³ This trend appears to be increasing.

Managing Potential Problems with Vicarious Liability

Potential Liability For All Medical Staff Members

Hospitals commonly try to associate themselves closely with their doctors, and frequently make complimentary statements about the quality of care that “their” physicians can provide. This can often be seen in marketing materials and can increasingly be seen on hospital websites. This is the type of activity that gave rise to liability in the cases first discussed.

The best approach for handling this type of exposure is to know how and where the hospital’s name is being used. Risk management needs to be aware of all marketing programs and should periodically monitor marketing materials. Marketing materials should never be allowed to imply that a physician is an employee of the hospital, unless he or she is, in fact, an employee. If the hospital places its name on a building, it should be prepared to take responsibility for activities within the building or it should have taken sufficient steps (in the eyes of the public) to distance itself from the activities within the building.

If the hospital performs services for physicians, such as billing and collections, it must be careful to ensure that it does not appear to be the physicians’ employer. It may be reasonable for a patient to assume that, since he sees the physician at XYZ Hospital Medical Plaza and receives a bill for those services from XYZ Hospital Medical Billing Service, the physician is employed by XYZ Hospital. It may be appropriate to set up a billing service with a completely different name and address to handle physician billing, if this service is performed. In addition, of course, if billing or other services are provided by the hospital, the services should be provided at fair market value to avoid corporate compliance problems.

The hospital should also be careful to ensure that it does not appear to be the site of all physician activity. For example, in one case in Illinois a patient was referred to a specialist while he was an inpatient at a hospital. Every time he saw the specialist it was in the hospital or in the office building next door to the hospital, and all services were performed in the hospital. Following surgery the patient was paraplegic. The physician was held to be the hospital’s agent.⁴ Physicians may, on occasion, see patients for treatment in the hospital in outpatient settings or in the ED for minor procedures, and rarely see them in his or her office. This writer found an orthopedist who was seeing all of his patients for re-visits in the hospital’s ED. This type of activity merely reinforces the perception that the hospital is responsible for the actions of the physician.

Potential Liability for Certain Types of Physicians

The remedy for the problem of vicarious liability for the actions of “hospital-based” physicians is neither simple nor foolproof. There are steps that hospitals can take to deal with the ostensible agency problem, although some of them may be unpalatable to the medical staff, marketing or administration. Obviously, patients need to understand the actual state of affairs with regard to the independent members of the medical staff, which may mean putting some distance between the medical staff and the hospital. One way to do this is to place signs in public places advising patients and their families that the members of the medical staff are not employees of the hospital. Another way to do this is in informational materials that can be given to patients at the time of treatment. This latter approach has an added advantage, because the patient can be advised of the multiple bills that he or she will receive from the hospital and the various practitioners who will provide or have provided services.

Any approach has inherent flaws, however, that must be appreciated. The court in *Simmons v. Tuomey Regional Medical Center*⁵ rejected the concept of signage disclaiming responsibility for the actions of the emergency physicians as independent contractors, because it felt that some patients coming into an ED will not be able to read or understand the signs due to their medical conditions. This logic may not necessarily apply in the case of hospital based physicians other than ED physicians. However, this holding also has a fundamental legal flaw: courts are supposed to decide the case before them, rather than hypothesizing about all potential cases that might come before them. Thus, if the patient did have notice of the status of the medical staff members, there should be no vicarious liability on the part of the hospital. There may still be vicarious liability for patients who did not receive notice, but this should be a relatively small subset of the total patient

population. But failure to take any action may mean that this doctrine will continue to expand.

North Carolina's Approach To Date

The approach taken by North Carolina courts, based on limited research, appears to be somewhat different than the approach taken by other states. North Carolina appears to have included some of the test for liability for the actions of an independent contractor in its test for agency. It appears that the test in North Carolina is whether the employer "has retained the right of control or superintendence over the contractor or employee as to details."⁶ This is a very traditional test to determine whether someone is an independent contractor or an employee, and one on which the hospital should normally prevail.

Fortunately or unfortunately, the law is a dynamic and changing entity. The change in the law was a very rapid and dramatic one in all of the states in which expansive vicarious liability has been found. Hospitals in North Carolina may not have not been subjected to vicarious liability in the past, yet should still be prepared to deal with it if the law changes.

¹ *Malanowski v. Jabamoni*, 228 Ill. Dec. 34, 688 N. E. 2d 732 (Ct. App. Ill. 1997).

² *Goldberg v. Isdaner*, 2001 Pa. Super. 180 (Pa. Super. Ct. 2001)

³ South Carolina (*Simmons v. Tuomey Regional Medical Center*, 533 S. E. 2d 312 (S.C. 2000) (hospital liable for the actions of ED physician)); Ohio (*Clark v. Southview Hospital & Family Health Center*, 628 N. E. 2d 46 (Oh. 1994) (ED physicians)); Indiana (*Sword v. NKC Hospitals, Inc.*, 714 N. E. 2d 142 (Ind. 1999)); Montana (*Butler v. Domin*, 15 P. 3d 1189 (Mont. 2000)); Wisconsin (*Pamperin v. Trinity Memorial Hospital*, 423 N. W. 2d 848 (Wis. 1988)); Michigan (*Grewe v. Mt. Clemens General Hospital*, 273 N. W. 2d 429 (Mich. 1978)); West Virginia (*Torrence v. Kusminsky*, 408 S. E. 2d 684 (W. Va. 1991)); Kentucky (*Paintsville Hospital v. Rose*, 683 W. W. 2d 255 (Ky. 1985)); Mississippi (*Hardy v. Brantley*, 471 So. 2d 358 (Miss. 1985)); California (*Mejia v. Community Hospital of San Bernardino*, 99 Cal. App. 4th 1448, 122 Cal. Rptr. 233 (Ct. App. Cal. 2002) (hospital liable for actions of radiologist)).

⁴ *McCorry v. Evangelical Hospitals Corp.*, 331 Ill. App. 3d 668, 771 N. E. 2d 1067 (Ct. App. Ill. 2002).
⁵ 533 S. E. 2d 312 (S.C. 2000).

⁶ *Hayes v. Elon College*, 224 N.C. 11, 15, 29 S. E. 2d 137,140 (N. C. 1944); quoted in *Hylton v. Koontz*, No. COA 99-1053 (Ct. App. N. C. July 5, 2000) (court held that hospital was not liable for the actions of anesthesiologist).



Mark Your Calendars!

Next Meeting:

May 12-14, 2004

**Holiday Inn SunSpree
Wrightsville Beach, NC**

HIPAA Puzzle – Answer Key

ACROSS

1A PHI
 2A accounting
 3A HIPAA
 4A oral
 5A verify
 6A associate
 7A training
 8A officer

DOWN

1D necessary
 2D hotline
 3D authorization
 4D optout
 5D notice
 6D fines