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The Business of Medicine

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HUMAN RESOURCES

10 things to know about employment practices liability insurance

Employment practices liability insurance, known as EPLI, provides coverage to employers against claims made by employees alleging discrimination (e.g., on sex, race, age or disability), wrongful termination, harassment and other employment-related issues. Workers' compensation, issues involving unemployment insurance and ERISA are excluded.

EPLI is not meant to replace sound employment practices. In fact, most insurers will not insure a company unless it has some basic employment practices in place. Employee handbooks and post-incident investigation practices are some of the significant items that insurance companies expect an employer to have when applying for an EPLI policy. You should be prepared for the insurance company to scrutinize all of the HR functions. EPLI costs are dependent upon the size of the organization, the type of business and other risk factors.

Coverage considerations

All policies affording coverage for employment-related liabilities are not created equal. Knowing which liabilities are covered by which policies—and what to do when potential liability arises—is critical to maximizing your insurance return. A good place to start is by understanding the different types of coverage:

- *Commercial general liability* (CGL) coverage is a staple in many practices' insurance portfolios. But as broad as such coverage may be, most CGL policies afford only limited coverage for employment-related liabilities.
- *Directors and officers liability insurance* (D&O) protects the practice as well as its individual directors and officers.
- *Employment practices liability insurance* (EPLI) can bridge any gaps that might exist for claims brought by current or former employees.

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As there are no standard EPLI policies, each policy and proposal must be evaluated on its own merits, though similarities have become common over time. Here are some issues that should be considered.

Claims-made policy

Most liability insurance policies (general liability, automobile, workers' compensation) pay for ***events that occur during the policy period***. For example, an auto insurance policy will pay for an accident that occurs while the policy is in force. EPLI policies, however, pay for ***lawsuits filed during the policy period; the wrongful act could have occurred years before.*** Claims-made policies respond only when a suit is filed, or when a strong threat of a suit exists.

- *Claims-made policy:* Pays based on the date of the lawsuit.
- *Occurrence policy:* Pays based on the date of the accident or occurrence.

The downside of a claims-made policy comes if the policy is canceled. For example: An EPLI policy is put in force January 1, 2014, and is renewed in 2015 and 2016. In 2017, however, the practice decides to end the coverage because the premium has increased. Six months later, a letter from an attorney arrives announcing a lawsuit for discrimination in medical leave that occurred in 2017. There is no coverage.

Although the policy was in force at the time of the alleged discrimination, the policy was not in force when the suit was filed. The solution to this problem is the extended reporting period found in most policies.

Extended reporting period/tail issues

Claims-made policies only provide protection for lawsuits and actions brought during the policy period. In the event that coverage is replaced or cancelled, protection may be desired for events that took place prior to expiration/cancellation but for which no claim has yet been filed. This coverage is called a "tail" or "extended reporting period" (ERP).

Limit of coverage

Most EPLI policies have a limit per occurrence and a policy limit of coverage for the total of all claims, called an aggregate limit. As claims are paid, you use up the limit of coverage available for future claims.

Defense within limit

Most EPLI policies include the cost of defending a claim (e.g., attorneys' fees) within the policy limit of liability. The defense costs of a claim can use up your insurance. When looking for the correct limit of coverage, consider the cost of the legal system in your calculations.

Definition of wrongful employment practice

Each EPLI policy will contain a definition of the wrongful acts that are included in the policy. Here are some acts to be considered when reviewing coverage:

- Discrimination
- Wage & hour
- FMLA violations
- Social media

- Wrongful discharge
- Sexual harassment, gender and sexual orientation claims
- Hostile workplace environment

If an act is outside the definition of wrongful act, there is no coverage.

Definition of harassment

Some policies narrowly define this coverage as "sexual harassment." A better and broader definition is "workplace harassment" or "harassment including sexual harassment."

Special insurance company provisions

Some employment practices liability insurance policies include special features. Usually these are measures to prevent losses. Insurers may provide access to a "hotline," allowing free access to experts to discuss employment actions and situations. The purpose is to give the practice access to information and opinions on issues that could lead to a claim.

Another feature offered by some insurers is a reduction in the deductible applied to a claim if the practice called an attorney prior to the termination of an employee. Others allow you to call your own attorney. Should a claim result, the deductible may be reduced by half.

Retroactive date/prior acts coverage

We discussed above the idea that claims-made insurance policies respond to claims brought during the policy period. Many policies include a date after which a claim must occur in order for the policy to respond—a retroactive date. When changing insurance companies, it is vital to understand the new policy retroactive date. The use of tail coverage may be necessary if the retroactive date is not sufficiently in the past.

When buying coverage for the first time, find out how "prior-acts" will be handled. Some insurers exclude all past occurrences. Some will only exclude "pending and prior litigation." In other words, if you knew that the incident was going to result in a lawsuit, there is no coverage.

Third-party coverage

Some insurers offer coverage that includes allegations of harassment or discrimination to non-employee third parties. For example, a customer alleges that a clerk refused service due to her race or ethnicity. Review the definitions of third party and the wrongful acts that are included in the extra coverage.

Final thoughts

Having total peace of mind in today's litigious society may not be possible, but having adequate insurance to cover employment related claims should be at the top of any employer's to-do list. Talk with your broker now rather than later, and once EPLI coverage is in hand, annually have the policy reviewed and updated to ensure that it encompasses the practice's current risk needs.

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CONGRESSIONAL ACTION

Affordable Care Act: Is repeal for real this time?

A new Republican effort to repeal and replace the Affordable Care Act (ACA) is coursing rapidly through the Senate, but lawmakers are pressed for time and face the same obstacles that torpedoed their earlier, higher-profile repeal attempt in July.

The latest bill, sponsored by Sens. Lindsey Graham (R-S.C.) and Bill Cassidy (R-La.), must be passed by Sept. 30 or it will no longer benefit from the procedural protections afforded by the "reconciliation" rules, which allow passage with a simple majority (just 50 votes with Vice President Mike Pence to provide the 51st tie-breaking vote). After Sept. 30, any bill would require a two-thirds majority of the Senate (60 votes) to pass.

Similar provisions, with a new twist

The Graham-Cassidy bill maintains the same overall shape of previous Republican repeal legislation, including major cuts to the Medicaid program and the elimination of the ACA's federal subsidies for poor people to cover premium costs. But Graham-Cassidy also adds a new element: a block grant to each state that amounts to $1.2 trillion over

seven years, from 2020 to 2026. The block grant fund would be paid for by some of the taxes established by the ACA, though the total amount would be far less than what the ACA would pay out over the next decade.

The block grant gives each state a fixed amount of federal dollars to spend on healthcare and insurance costs, with practically no strings attached. It would be up to states to determine how to use the money, though it must be related to healthcare. States could choose to use the cash to fund high-risk pools, boost provider payments as they see fit, offer residents insurance subsidies, or any combination of measures.

The fixed amount would be determined by an intricate formula that accounts for population density, income, and other variables, but it would ultimately result in some states seeing a major reduction in federal funding for healthcare. The states that opted to accept the ACA's Medicaid expansion would be disproportionately affected, meaning states like California, Connecticut, Florida, Massachusetts, New York, and Virginia could see as much as a 50% drop in federal dollars by 2026.

The rest of Graham-Cassidy is fairly familiar to those who have been following the Republican repeal campaign. It keeps many of the measures that featured in previously proposed bills, such as eliminating the individual mandate requiring everyone to buy health insurance, and allowing states to opt out of ACA mandates, including the ban on higher premiums for individuals with preexisting conditions, and the comprehensive "essential benefits" package that all plans would have to offer.

GOP has a need for speed

Apart from the Sept. 30 deadline to allow passage of the bill with just 50 Senate votes, Graham-Cassidy must contend with the same problems that blocked previous GOP bills. More moderate Republicans, particularly in states that accepted the ACA's Medicaid expansion, would be put off by the massive Medicaid cuts and the reduction in premium support and benefits across the board, while more conservative Republicans would object to the bill retaining aspects of the ACA, such as its taxes and costs.

The Sept. 30 deadline may not offer enough time for the non-partisan Congressional Budget Office (CBO) to offer a full analysis or "score" of the projected impacts of the bill, and the short time-table definitely does not allow the Senate time to form multiple committees to examine the bill and propose changes. The bill is on life support as this issue *The Business of Medicine* goes to press, with Sen. John McCain (R-Ariz.), releasing a statement on Sept. 22 that he would vote against Graham-Cassidy. McCain, who provided the backbreaking "no" vote against the last GOP bill in July, cited the same reasons for opposing Graham-Cassidy: that it's a rushed bill with no Democratic support and no time for comprehensive analysis.

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CODING

Practices, coders react to proposed E/M changes

CMS wants to simplify E/M coding and documentation in 2018, and it could start by eliminating its fixed requirements for the history and exam components of E/M services. To gauge how this would affect practices, *The Business of Medicine* looked at sample progress notes for E/M services and talked to coders.

Remember: CMS is proposing to allow history and exam to be documented at the discretion of the rendering provider in its 2018 Medicare Physician Fee Schedule (PFS) proposed rule. E/M code level would be based solely on the medical decision making (MDM) component and, in the case of counseling-dominated visits, the amount of face time spent with the patient. This isn't the only option CMS is considering for 2018, and it could eventually look at streamlining MDM as well, but the short-term focus is on the history and exam.

Is history or exam tougher to capture?

Under the longstanding CMS 1995 and 1997 guidelines, named for the years in which they were established, the history, exam, and MDM must meet certain levels to support different levels of E/M service. Codes for new patient visits, or initial visits in the hospital, currently require all three of these components to be met. Codes for established patient visits or subsequent visits in the

hospital only require two of the three (though most payers including Medicare require MDM to be one of the two).

Specialties have a harder time than primary care with the exam component because their most commonly treated illnesses and injuries usually involve just one or two organ systems. Under the 1995 guidelines, a comprehensive exam (required to support the highest level codes such as **99204**, **99205**, **99222**, and **99223**) requires documenting at least one element, or bullet, from at least eight different organ systems. The 1997 comprehensive exam requirements are even more demanding: a total 18 bullets, in the form of at least two bullets from each of nine different organ systems.

With the advent of electronic health records (EHRs), most providers now capture the physical exam by ticking checkboxes in a premade template, which makes getting eight organ systems easier, says Melissa Hainz, CPC, lead coding specialist at the Department of Otolaryngology Head and Neck Surgery at Oregon Health & Science University in Portland.

Instead, documenting the history component is more difficult for her physicians, Hainz says. "Our physicians are pretty good at documenting exams specific to the problems in a given visit, and EHR templates help," she says. "But when it comes to history, and the HPI [history of present illness], that can be hard to document because it's different based on why the patient is presenting that day."

For example, her physicians invariably document a comprehensive history for patients with serious conditions such as head and neck cancers. Key to a comprehensive history is the HPI, which requires at least four elements (such as location, duration, quality, context, modifying factors, associated signs and symptoms, etc.) to support the higher level services.

But when her physicians see cases that are more common but could still require significant work, such as patients with persistent sinus problems or difficult-to-diagnose hearing loss, a comprehensive history is more difficult to capture.

"From my standpoint as a coder – and I believe E/M coding is so tedious and cumbersome especially for what you're reimbursed – not having tick off all those marks for history, review of systems, would make a big difference," Hainz says.

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Nov. 8-10	**2017 Annual Georgia Association of Orthopaedic Executives (GAOE) Conference,** Pine Mountain, GA – Sean Weiss
Nov. 9	**FREE Webinar, "Sampling 101: A Primer for Internal and External Audits,"** 2 to 3pm ET, Frank Cohen
Nov. 16-17	**NAMAS CPMA Boot Camp,** Tallahassee, FL

CMS signals a shift in focus to MDM

Templates that prompt physicians for every possible history or exam bullet, whether they are clinically relevant or not, can make it easy to consistently document the highest level of history and exam, and some EHR systems then use these levels to recommend much higher E/M code levels than are medically necessary. CMS acknowledges this in its 2018 PFS proposed rule, writing that its E/M guidelines "have not been updated to account for significant changes in technology, especially EHR use, which presents challenges for data and program integrity and potential upcoding given the frequently automated selection of code level."

If CMS does finalize its proposal to leave history and exam to provider discretion, the result would be more focus on the key component of E/M codes that isn't so easily quantified: MDM. "I think this would lead to an increased scrutiny on MDM, and as time progresses, provider documentation will shift to focus on that," Hainz says.

While the concept of MDM has been criticized for having too many gray areas, Hainz believes that less time spent worrying about checking too many or too few history and exam boxes means more time for physician to improve MDM documentation. "It means code levels will depend more on having coders who understand the clinical conditions your providers treat."

The answers will start to come on Nov. 1, the date by which CMS is statutorily required to release its PFS final rule for 2018.

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COMPLIANCE

Supreme Court ruling weakens whistleblower suits

A recent Supreme Court ruling will reduce the success rate of whistleblower lawsuits made against healthcare payers and providers under the False Claims Act (FCA), though it also reaffirms the most consequential aspect of the FCA: the concept of "implied certification."

The case is *Universal Health Services v. United States ex rel. Escobar* and after the Supreme Court ruled on the case, we received many questions from attorneys who did not specialize in healthcare law but were taking on potential FCA cases on behalf of practices and hospitals under audit by the HHS Office of Inspector General (OIG). Though the details varied, the core question these attorneys had was, given the Supreme Court ruling, just how liable was a provider who submitted claims they believed to be compliant with billing and coding rules?

'Implied certification' is key

Prior to *Escobar*, the courts have generally applied the concept of "implied certification" broadly, which has favored plaintiffs in *qui tam* (aka "whistleblower") lawsuits. **Implied certification** means that when an entity submits a claim, that entity guarantees (certifies) that it has complied fully with all applicable statutes,

regulations, and contractual terms. Therefore if any of these applicable requirements are violated, the False Claims Act has been violated, and a whistleblower case can be filed. Many of these cases have involved individual whistleblowers highlighting significant, even scandalous fraud. However, as news has gotten out about the now widely-known provision of the FCA that requires the government to give whistleblowers a substantial portion of recovered and punitive monies, a slew of such cases have cropped up where it could be argued that the whistleblowing plaintiffs were more motivated by the profits, and the alleged violations were relatively minor and possibly unintentional.

In *Escobar*, the Supreme Court upheld and reaffirmed the principle of implied certification, but placed conditions on how aggressively it can be applied: "We hold that the implied certification theory can be a basis for liability, at least where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths."

However, in the same ruling, the Supreme Court also held that an erroneous claim doesn't always support an FCA violation because the errors may not be "material." The term "material" or "materiality" essentially means whether it matters to the outcome, according the Court. Thus if Medicare knows about a minor violation but continues paying claims with this violation, the violation is not considered "material" and can't support an FCA suit. But if Medicare would never pay for a claim if it knew about a certain violation, then it *would* be considered a material basis for an FCA violation suit.

How the ruling applies to healthcare claims

Let's take a look at how the ruling impacts our day-to-day business. In the case *United States ex rel. Petratros v. Genentech Inc*, the plaintiff alleged that a provider entity failed to disclose the risks associated with a prescription drug, and therefore it was able to write more scripts and receive more payment from Medicare. However, the Third Circuit Court of Appeals rejected this argument because there was no finding that failing to disclose all the possible risks was material to Medicare's decision to pay for the associated claims. In other words, while Medicare could potentially decline payment for this reason, it didn't, and thus the plaintiffs failed to satisfy the materiality requirement.

But let's say instead that the case involved mental health services and therapy. What if a practice provided such services, including the prescription of drugs to treat bipolar disorder, and the patient has an adverse reaction to one of the drugs and dies? Later it is found that none of the staff at the practice were actually qualified to provide mental health care or even write prescriptions; they had misrepresented their professional qualifications. Would Medicare pay for services that it requires physicians to perform, but were actually performed by nurses? This is the actual case that was argued in *Escobar*, with the plaintiffs being the parents of the patient who died, and the defendant being a healthcare provider group whose staff treated her.

The Supreme Court took up the case after two lower courts disagreed over whether the actions of the provider group violated the FCA. Having clarified its definitions of "implied certification" and "materiality," the Supreme Court has cancelled all previous lower court rulings and sent the case back to those courts for re-litigation under these clarifications.

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REVENUE CYCLE MANAGEMENT

Anthem stops paying for outpatient hospital imaging

Anthem Blue Cross Blue Shield has announced that it will no longer pay for MRI and CT scans performed in the outpatient setting by hospitals in all 14 states that it operates in. The policy is being phased in, hitting several states at a time, and will be in full effect by March 2018.

The move affects any preauthorization request for CT and MRI scans in a hospital setting. All such requests will be "reviewed for medical necessity" by an Anthem subsidiary called AIM Specialty Health, according to Anthem's online

list of frequently asked questions (FAQ). While Anthem says that it will pay for the scans if medically necessary, its new definition of medical necessity is highly restrictive.

Anthem will now use its CG-MED-55 guideline, which defines medical necessity for MRI and CT scans as follows.

"An advanced radiologic imaging procedure in the hospital outpatient department is considered ***medically necessary*** when any of the following are present:

A. The services being provided are only available in the hospital setting; ***or***

B. The individual requires an obstetrical observation; ***or***

C. The individual is receiving perinatology services; ***or***

D. There are no other geographically accessible appropriate alternative sites for the individual to undergo the procedure, including but not limited to the following:

1. *Moderate or deep sedation or general anesthesia is required for the procedure and a freestanding facility providing such sedation is not available;* ***or***
2. *The equipment for the size of the individual (that is, very small or very large) is not available in a freestanding facility;* ***or***
3. *The individual has a documented diagnosis of claustrophobia requiring open magnetic resonance imaging which is not available in a freestanding facility."*

When a pre-authorization request fails to meet the standards above, Anthem will deny it and offer a list of free-standing imaging centers as an alternative to patients. Providers are allowed to appeal such a denial under the same process as they would appeal any medical necessity denial, Anthem states.

Essentially, the new guidelines are aimed at reducing the cost to Anthem, as many patients will most likely have to go out of their way to a free-standing facility when they could receive the same scans in the outpatient hospital setting. "Anthem's primary concern is to provide access to quality and safe health care for our members," the insurer says in its FAQ. "We are also committed to reducing overall medical cost where possible when the safety of the member is not put at risk."

Hospitals, smaller practices will feel impact

While hospitals that offer CT and MRI scans in the outpatient setting will take a painful financial hit because of the Anthem policy, smaller practices that refer to such hospitals will also have to change their behavior. Now, such practices will need to refer Anthem patients in the affected states (see below) to free-standing facilities approved by Anthem.

The policy has already been in effect for Indiana, Kentucky Missouri, and Wisconsin (since July 1). More recently, Colorado, Georgia, Nevada, New York, and Ohio became subject to the rule, on Sept. 1. The remaining five states are California, Connecticut, Maine, New Hampshire, and Virginia (excluding the Northern Virginia suburbs of Washington, D.C.). The policy becomes effective in those states sometime in 2018, and all by March 2018 with the exception of New Hampshire, for which Anthem has not yet given an effective date.

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