

CSAC - Excess Insurance Authority

Medical Malpractice Programs

Claims Handling Guidelines

This manual is intended to provide information to participants in the CSAC-Excess Insurance Authority Medical Malpractice Programs regarding the insurance program, Risk Management Services (RMS), reporting requirements, and incidents and claims procedures. The contents of this manual should be provided to all management personnel involved in both county and hospital risk management. Participating counties are responsible for the communication of this manual's contents to appropriate county personnel.

Copies can also be requested through:

RISK MANAGEMENT SERVICES

P.O. Box 724
Sebastopol, CA 95473
Telephone: (707) 792-4980
Facsimile: (707) 792-4988
E-mail: claims@rmscotati.com

CSAC-EXCESS INSURANCE AUTHORITY

MEDICAL MALPRACTICE PROGRAMS

I. CSAC-Excess Insurance Authority (CSAC-EIA)

The CSAC-Excess Insurance Authority (CSAC-EIA) was established in 1979 to provide excess insurance coverage, risk management, and self-insurance services to California counties.

The CSAC-EIA is a joint-powers agency governed by a Board of Directors consisting of one representative from each member county. Currently, over 53 of the 58 California counties are members, ranging in population size from Santa Clara County to Alpine County.

The CSAC-EIA has dramatically reduced member counties' excess insurance costs by utilizing the combined purchasing power and financial size of the group. The CSAC-EIA has played an important leadership role in this marketplace by pioneering new and innovative methods of financing risk, and even non-member counties have benefited by the competitive role, which the CSAC-EIA has assumed in this marketplace. Major programs include Primary Workers' Compensation, Excess Workers' Compensation, Primary Liability, Excess Liability, Liability Program II, Property, Property Program II, and Medical Malpractice.

Additionally, the CSAC-EIA has implemented numerous innovative risk management strategies designed to assist all counties in effectively administering self-insurance programs. Such strategies include claims audits, actuarial studies, claims management information systems, and loss prevention audits.

The Medical Malpractice Programs provide professional and medical liability coverage to member counties, hospitals, physicians and health departments on a claims-made coverage basis. Program I, established June 1, 1988, provides coverage for counties with large hospital facilities. Program II, established January 1, 1991, provides coverage for counties with smaller hospital facilities and/or non-hospital healthcare facilities. The "Mid-Mal" Program, established July 1, 1992, provided coverage for counties with mid-sized hospital facilities or risk exposures. Since October 1, 2000 the "Mid-Mal" counties merged with Program I and are now identified as Program I counties.

The lead underwriter for all programs' excess coverage is Lexington Insurance Company. CSAC-EIA has contracted with Risk Management Services (RMS) since 1992 to provide claims and risk management services to member counties.

Should you have any questions regarding CSAC-EIA or the Medical Malpractice Programs, please contact:

**CSAC-Excess Insurance Authority
Mr. Michael Fleming
General Manager
3017 Gold Canal Drive, Suite 300
Rancho Cordova, California 95670
(916) 631-7363**

Information about the CSAC-Excess Insurance Authority, and about its various programs, can also be accessed on the internet at www.csac-eia.org.

II. Risk Management Services (RMS)

Risk Management Services (RMS) provides claims and loss prevention services to the healthcare industry, and has extensive experience in all aspects of hospital and professional liability insurance, claims administration, and healthcare risk management. RMS contracts with CSAC-EIA to provide services to the participating counties in the Medical Malpractice Programs. These services are designed to assist in developing effective claims handling and risk management systems. A list of telephone numbers and contacts at RMS can be found in Appendix A.

In order to better understand RMS's role in the respective Programs, the contracted services are outlined as follows:

Medical Malpractice Program I

Conduct annual audits of each county's open claims files and claims-handling system.

Review each county's claims to assess the effectiveness of the Program and determine any exposures, which may affect the excess coverage.

Oversee the management of all claims reserved at, or having the potential to affect, the excess coverage.

Develop an excess claims management system.

Establish an incident reporting system to provide uniformity throughout the participating counties and to target "major incidents."

Provide consultation and loss prevention assistance during visits focusing on each county's risk management systems and high-risk areas; activities during visits may include providing individualized training programs, educational materials, audits, assistance with policies and procedures, and assessments that target key risk management issues for healthcare and administrative staff in the County, or in specific units of the County's healthcare department or agency.

Provide ongoing 24-hour risk management consultation and advice by telephone, as well as bulletins, training programs, and conferences designed to provide all of the Counties with current information regarding risk management concerns in the healthcare field.

Medical Malpractice Program II

Provide first-dollar claims management and administration, including initial handling of claims filed under the Government Tort Claims Act (Government Code 900 et seq.).

Provide investigation, case management, and settlement assistance, with authority provided by the participating county and the CSAC-EIA.

Provide counties, the Medical Malpractice Program Committee, and the CSAC-EIA with updated quarterly claims runs with reports to the excess carrier as directed; additionally, perform all mandatory state and federal reporting.

Provide counties, the Medical Malpractice Program Committee, and the CSAC-EIA with an initial evaluation and annual follow-up of each participating county's healthcare risk management activities.

Provide ongoing 24-hour risk management consultation and advice by telephone, as well as bulletins, training programs, and conferences designed to provide current information regarding risk management concerns in the healthcare field.

III. Incident Reporting

An incident is any alleged negligent act resulting in bodily injury or property damage which involves allegations of medical malpractice, negligence, discrimination, defamation, or

invasion of privacy, and occurs in connection with the operation or maintenance of county healthcare service facilities or extensions of such facilities. An incident also includes any other alleged injury to third parties, other than county employees, which occurs in such facilities.

MANDATORY REPORTABLE INCIDENTS

Major incidents, as listed below, must be reported to RMS:

Death

Brain damage

Any injuries significantly affecting the capacity of sight, taste, smell, or hearing

Amputation

Any loss of use of limbs

Any spinal cord damage and any real or suspected paralysis including paraplegia, quadriplegia or hemiplegia

Disfigurement

Reproductive organ loss or impairment

Burns

Any other serious type of bodily injury

Program II counties additionally report any lawsuit related to medical malpractice

All listed "major incidents" must be reported to RMS, as well as the County Risk Manager, within 24 hours of notice. It is essential that an effective incident reporting system be in place. The ramifications of untimely reporting are:

The county can become liable for the entire claim settlement, thereby forfeiting its primary and/or excess coverage.

The future of the non-complying county's participation in the CSAC-EIA Programs could be jeopardized.

The entire CSAC-EIA can be affected at renewal of the insurance coverage through increased rates or non-renewal of coverage.

Major incidents should be reported directly to the RMS office either by telephone, e-mail, verified FAX communications, or by certified, return receipt requested United States mail.

Once RMS receives the report of the incident, it will notify the appropriate parties to secure future coverage should the incident result in a claim.

Communication of the incident via telephone, e-mail, FAX, or U.S. certified mail is a privileged communication protected by the attorney-client privilege and California Evidence Code 1157, et seq. Never provide copies of any incident report to a patient or claimant, and never place a copy of an incident report in the patient's chart.

IV. Incident Handling

Once a "major incident" has been brought to the attention of appropriate county staff and reported to RMS, the following actions should be taken within 48 hours to assure proper handling of the situation and to establish appropriate contacts and procedures for all future activity regarding the incident:

Identify and interview all persons involved in the incident as well as any pertinent witness. Upon completion of the interviews, a brief and factual report on the circumstances of the incident and the role of each individual should be prepared. The report should be kept in the risk management file only, with a copy sent to RMS. (Medical Malpractice Program II participants should contact RMS directly to initiate these procedures.)

Secure all involved parties. Each person interviewed should be instructed not to speak with anyone regarding the incident without prior approval of appropriate county staff. This would include friends, relatives, co-workers, reporters, lawyers, adjusters and investigators.

Secure any physical evidence involved in the incident. This would include medications, instruments, bio-med electronics, x-rays, etc. The evidence should be tagged for identification and stored in a secure place designated by appropriate county staff.

Secure the medical record. Appropriate county staff should review all pertinent medical records. (RMS will review all pertinent medical records for Program II participants.) The Medical Records Department should be instructed that records will remain in risk management lock-up and will not be released without written authorization from appropriate county staff. Additionally, appropriate county staff should be notified immediately of any

request for the records by employees, physicians, lawyers, investigators, or the patient.

V. Claims Reporting and Handling Guidelines

The mandatory reporting of claims to RMS follows the same guidelines as the reporting of major incidents. In most cases, the claims reporting process will be accomplished through the County Risk Manager's office since the claims will be filed against, and processed at, the county offices. Special separate updated guidelines for Program I and Program II participants are distributed to the participating counties on a regular basis and are available on the RMS website at www.rmscotati.com. A copy of each set of guidelines is also included in Appendices B and C of this manual.

It is important for all appropriate county staff to be knowledgeable about the Government Tort Claims Act, specifically Government Code sections 910, 910.8, 911.2, 911.3, 911.4 and 911.6 concerning contents of claims, insufficient claims, rejection of claims, and the filing of late claims. A summary of the pertinent provisions of the Government Tort Claims Act appears in Appendix D of this manual.

Healthcare risk management staff should also be familiar with general policies and recommended guidelines for claims handling and processing.

As a general rule, all claims should be rejected by sending a written notice to the claimant within 45 days, or by operation of law after 45 days, when prudent judgment indicates:

- a. the issues of liability or damages are not clear,
- b. further investigation is required,
- c. there are other matters which need to be resolved, or
- d. there is no known basis of liability against the county.

Please note: "Notices of Intent to Sue" filed under provisions of Code of Civil Procedure section 364 are sometimes sent to the county, health department, hospital, and/or physicians. These "notices" are considered "claims" for purposes of the Government Tort Claims Act and should be treated as such. Similarly, informal notice of a potential claim should be treated as a formal claim for purposes of initial claims handling under the Government Code.

Reporting and Excess Claims Management: Program I

Once a "major incident" or potential excess claim has been reported or filed with the county, it must be reported to RMS. RMS will determine if an incident report has been previously filed on the claim. If the claim is reserved at a level equal to or greater than one-half of the county's self-insured retention or falls under the previously defined "major incident," RMS will oversee management of the claim for purposes of the excess insurance coverage.

This management would include the following:

- Review of medical records pertinent to the claim
- Direction of investigation activities
- Recommendations regarding appropriate consultant and expert reviews
- Coordination of defense counsel
- Representation of CSAC-EIA in all settlement negotiations

RMS must be copied on all correspondence pertaining to excess claims that fall under the mandatory reporting requirements. The County Risk Manager should therefore instruct all county counsel, defense counsel, and adjusters to copy RMS, as well as provide RMS full cooperation in their claims management efforts.

RMS will keep a claims run on all excess claims by county, and review the claims run quarterly with each County Risk Manager, as well as provide an annual summary to both the county and CSAC-EIA.

RMS will also provide notification to the excess insurer on a timely basis as required to secure coverage.

The County Risk Managers should be aware that California Health and Safety Code 1305 and Business and Professions Code (sections 801 et. Seq.) require the county, as a self-insurer, to report judgments and settlements involving health care issues and health care professionals to the State Department of Health Services and various licensing bodies (e.g. the Medical Board of California). Additionally, the National Practitioner Data Bank must be notified of any judgment or settlement made as a result of a claim or incident arising out of the conduct of any licensed health care practitioner. This reporting requirement is the responsibility of the county and a system to facilitate the reporting should be in place. For more information or assistance regarding reporting, please contact RMS.

Reporting and Claims Management: Medical Malpractice Program II

Program II counties must report all claims, both the mandatory reportable major claims, plus all others, to RMS so that prompt review and investigation may be initiated. RMS will then make recommendations to the county on acceptance, rejection, timeliness or sufficiency of

each claim. RMS reviews the claim, obtains appropriate medical records, and discusses the case with appropriate county personnel to determine its recommendation to the county on acceptance, rejection, timeliness, or sufficiency of the claim. RMS will input the claim, all pertinent information, and reserves into a computer system for Program II counties.

Once a preliminary evaluation and/or recommendation have been established, RMS will report to the appropriate county staff. This report will provide information necessary to formulate a plan for handling the claim. RMS will implement authorized actions. This could include diary tracking of claims rejection, retention of consultant/expert review, settlement negotiation or defense counsel assignment and management.

RMS will handle all reporting to the excess carrier, whether mandatory or voluntary. A Notification Form will be sent by RMS to Lexington Insurance Company along with all required documentation. All mandatory reportable incidents, as well as potential excess claims will be reported. (All claims must be reported when the total combined amount reserved, loss and expenses, is \$100,000 or more.) All other incidents/claims are reportable on a discretionary basis by the individual county. These will only affect the aggregate of the year reported, and will not be carried over to a future year. This is a voluntary reporting, requested by the counties, to trigger coverage.

Additionally, RMS will handle all required federal and state reporting such as required by the National Practitioner Data Bank, Department of Health Services, and various professional Boards.

RMS is committed to a proactive/hands-on claims handling system and believes that expedient handling of medical malpractice claims results in overall cost reductions. In order to facilitate early closure of claims, RMS adheres to standard claims handling practices together with several additional procedures to assure effective claims management:

Prompt and comprehensive incident reporting systems

In-house investigation processes involving county staff identified and trained to conduct preliminary investigations. This assures accurate witness accounts, proper advice to involved personnel, secure storage of records and evidence, and prompt identification of a liaison within the facility for future handling of the claim.

Preliminary physician review of records to provide an early assessment of liability, future medical expenses, potential need for experts, and defensible issues.

Full compliance with the requirements of the Government Tort Claims Act (Government Code sections 910, et. seq.) and other related statutes. Initial investigation is designed to comply with the timetable for rejecting/accepting a claim.

Once a claim has been rejected or denied as late or insufficient, RMS tracks all important statutory dates, keying in on timely closure of the file. Copies of all claims filed with the Clerk of the Board should be submitted to RMS as soon as possible, either by mail or FAX.

Mail to: Risk Management Services
P.O. Box 724
Sebastopol, CA 95473

Fax to: Risk Management Services
(707) 792-4988

Active defense management. RMS actively works with defense counsel to assure that the defense is comprehensive, but cost-effective. Customized defense panel guidelines have been developed that set down criteria for reporting, discovery activity, setting of depositions, retention of experts, and settlements.

Active participation in settlement negotiations. RMS plays an active role in settlement negotiations and, when appropriate, alternative methods of settlement, such as periodic payments and reversionary trusts, are explored. When applicable, a liability appraisal system will be utilized as an integral part of the settlement.

VI. Risk Management/Loss Prevention Activities and Recommendations

CSAC-EIA and RMS are committed to developing effective risk reduction systems within the Medical Malpractice Programs. The risk management guidelines provided in this manual create a strong foundation for effective hospital/healthcare services risk reduction. A continuing effort will be made by CSAC-EIA and RMS to educate and provide information on healthcare risk management.

The following basic guidelines should either already be in place, or a plan of action should be promptly developed to institute them in each county:

An on-site hospital or healthcare services Risk Manager should be designated at each appropriate facility.

A written hospital or healthcare services Risk Management Manual should be available in each facility, which includes procedures, policies, and regulations.

Each County Risk Manager, as well as the hospital/healthcare services Risk Manager, should be aware of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and CMS regulations as they apply to risk reduction activities.

In-service education should be an ongoing tool to create an awareness in risk prevention for all hospital/health care services staff.

An appropriate incident report form, as well as a timely reporting system, should exist in order to provide quick response to incidents and to coordinate the activities of Risk Management and Quality Assurance.

Each county is encouraged to participate in all CSAC-EIA sponsored in-service training programs as well as identify individuals in the healthcare services system who will benefit by attending these sessions.

These guidelines provide the foundation for an effective healthcare risk management system. Combined with an ongoing risk management education program and proactive quality assessment activities, they result in an effective risk reduction program.

APPENDIX A

RISK MANAGEMENT SERVICES

**P.O. Box 724
Sebastopol, CA 95473**

phone: 707-792-4980

fax: 707-792-4988

E-mail: claims@rmscotati.com

Kenneth R. Maiolini, Partner
Pager: 707-493-2684
Cellular: 707-696-6710
Facsimile – Home: 707-829-5689
Voicemail: 707-792-4985 x205

Linda J. Garrett, J.D., Partner
Cellular: 707-696-6711
Facsimile – Home: 415-924-5989
Voicemail: 707-792-4985 x210
Alternate Number: 415-924-4980

Appendix A-1

APPENDIX B

CSAC-EXCESS INSURANCE AUTHORITY

MEDICAL MALPRACTICE PROGRAM I

EXCESS CLAIMS/INCIDENT REPORTING GUIDELINES

I. Reportable Claims/Incident

A. All claims or incidents falling under the following criteria must be promptly reported to Risk Management Services; these claims or incidents will then be immediately reported to the excess carrier. In order to properly trigger insurance coverage, it is essential that the county notify Risk Management Services of incidents meeting the following criteria:

Death

Brain damage

Any injuries significantly affecting the capacity of sight, taste, smell or hearing

Amputation

Any loss of use of limbs

Any spinal cord damage and any real or suspected paralysis including paraplegia, quadriplegia or hemiplegia

Disfigurement

Reproductive organ loss/Impairment

Burns

Any other serious type of bodily injury

Appendix B-1

B. All claims must be reported to the excess carrier when the total combined amount reserved (loss and expenses) is 50% or more of the Pool Program Retention. Risk Management Services will report these claims.

C. All other incidents/claims are reportable to the excess carrier on a discretionary basis. Reported claims will affect the aggregate of the year reported, and will not be carried over to a future year. This is a voluntary reporting requested by the counties, through Risk Management Services, to trigger coverage.

II. Reporting to Excess Carrier

Risk Management Services will handle all reporting, whether mandatory or voluntary. A Notification and all required documentation will be sent by Risk Management Services to Lexington Insurance Company.

III. "Occurrence Date"

The accepted occurrence date is the date that the incident/bad outcome occurred or the date that it was allegedly first discovered by the claimant.

APPENDIX C

CSAC-EXCESS INSURANCE AUTHORITY

MEDICAL MALPRACTICE PROGRAM II

CLAIMS HANDLING PROCESS – FIRST DOLLAR CLAIMS ADMINISTRATION

I. All Claims/Incidents

Step 1. All claims filed formally, or informally, with the Clerk of the Board of Supervisors, or with any other county department should be submitted to Risk Management Services as soon as possible; either by e-mail (claims@rmscotati.com), fax (707-792-4988) or mail to:

**Risk Management Services
P. O. Box 724
Sebastopol, CA 95473
(phone: 707-792-4980)**

Step 2. Risk Management Services will review the claim, obtain appropriate medical records, and discuss the case with appropriate county personnel to determine the need for any immediate action, and to formulate a recommendation to the county on acceptance, rejection, timeliness or sufficiency of the claim.

Step 3. Risk Management Services will input the claim, all pertinent information, and reserves into its computer data-base system for Program II counties.

Step 4. Risk Management Services, when appropriate, will conduct an investigation and/or request additional information in an effort to evaluate liability, damages, and further handling of claim.

Step 5. Once a preliminary evaluation and/or recommendation have been made, Risk Management Services will report to the appropriate county contact. This report will include information necessary to formulate a strategy for managing the claim.

Step 6. Risk Management Services will implement authorized actions such as diary tracking of claims rejection, retention of consultant/expert review, settlement negotiation, defense counsel assignment and management, and reporting.

II. Excess Claims/Incident Reporting

Risk Management Services will handle all reporting, whether mandatory or voluntary. The Notification and all required documentation will be sent to the excess carrier by Risk Management Services.

The "occurrence date" on all claims is the date that the incident/bad outcome occurred or the date that it was allegedly first discovered by the claimant.

All claims or incidents falling under the following criteria must be immediately reported to the excess carrier by Risk Management Services in order to properly trigger insurance coverage (and therefore must be immediately reported to Risk Management Services by the county):

Death

Brain damage

Injuries significantly affecting the capacity of sight, taste, smell or hearing

Amputation

Any loss of use of limbs

Any spinal cord damage and any real or suspected paralysis, including paraplegia, quadriplegia or hemiplegia

Disfigurement

Reproductive organ loss or impairment

Burns

Any other serious type of bodily injury

All claims must be reported to the excess carrier when the total combined amount reserved (loss and expenses) is \$50,000 or more. Risk Management Services will report these claims to the excess carrier. All other incidents/claims may be reported to the excess carrier on a discretionary basis. This is voluntary reporting, requested by the counties, to trigger coverage. Reported claims will affect the aggregate of the year reported, and will not be carried over to a future year.

App. C-2

APPENDIX D

The Government Tort Claims Act

The Government Tort Claims Act was adopted by the California State Legislature in 1963. Under the claims provisions of the Act, a claimant must file a claim with a public agency before the claimant can file a lawsuit for money damages against that public agency. An exception to this requirement is that a claim need not be filed if a lawsuit alleges violations of federal or state constitutional rights (e.g., deprivation of due process or discrimination). The legislature and various court decisions have stated that the purpose of the Act is to provide the public agency with sufficient information to enable it to adequately investigate a claim and to settle it, if appropriate, without the expense of litigation. To achieve this purpose, the Act requires a claimant to promptly present a claim to a public agency within a specific time after the accrual of the cause of action.

In medical malpractice claims, the cause of action accrues from the date of the claimant's actual or constructive discovery of the malpractice, and the claimant must file his or her claim within six months of that date. In a case of hidden malpractice, such as a missed sponge, the time does not start until the malpractice is actually uncovered, which may be several years later. In a case of obvious or suspected malpractice, such as operating on the wrong part of the body, the time starts to run immediately.

Claim Processing Steps Under the Government Tort Claims Act

Normally, the following steps apply to the processing of a medical malpractice claim against a county:

Claimant files a claim with the Clerk of the Board of Supervisors. A claim may take many forms, including a handwritten letter, attorney-drafted claim, county-supplied claim form, or a notice in the form of a Notice of Intention to Commence Action, under California Code of Civil Procedure section 364. Case law has established that any written correspondence from a potential claimant or an attorney which threatens the filing of a lawsuit against the county, or which seeks damages for alleged wrongdoing, should be treated as a claim against the county. (Government code sections 915 and 915.2).

The claim is immediately reviewed to determine if the information provided in the claim substantially complies with the legal requirements for claim content. (Government Code section 910).

If a claim fails to comply and is therefore defective, a written notice of "claim insufficiency" must be sent within twenty (20) days after the claim is filed with the Clerk of the Board.

If a notice of insufficiency is not sent, any defense as to sufficiency of the claim is waived. (Government Code section 910.8 and 911.).

If a claim is late because it was not timely filed within six (6) months from the accrual date, a written "late claim notice" must be sent to the claimant within forty-five (45) days after the claim was presented. This forty-five day period applies whether or not a public entity sends out a notice of insufficiency. If no late claim notice is sent, any defense as to the timeliness of the claim is waived. (Government Code section 911.3).

During the forty-five (45) day time period following receipt of a claim, an investigation of the claim is undertaken to determine whether liability exists. Although the county is under no legal obligation to conduct such an investigation, it is prudent practice to conduct an investigation when a claim is first received, rather than later when a lawsuit is received.

Within forty-five (45) days after a claim is filed, a decision is usually reached to accept, reject or compromise the claim. Claims are usually rejected when any of the following apply:

issues of liability or damages are not clear,
more information is needed, or
there is no known basis of liability against the county. (Government Code section 912.6)

If no action is taken on a claim after forty-five (45) days, the claim is deemed to be rejected by operation of law. (Government Code section 912.4).

It is prudent practice to send out a written rejection notice whenever a claim is rejected. The claimant must file any lawsuit within six (6) months from date of rejection notice. If no written notice is given, the claimant has two (2) years from the accrual date to file any lawsuit. (Government Code section 913).

Other provisions of the Act which apply to the processing of medical malpractice claims include the following.

After the initial six (6) month period to file a claim or upon receipt of a "late claim notice," there is a further six (6) month period during which a claimant may file an application with the Clerk of the Board for permission to file a late claim. (Government Code section 911.4).

Such an application must be accepted or denied within forty-five (45) days. (Government Code section 911.6).

If an application is denied, the claimant then has six (6) months from the denial date to petition the Superior Court for relief from the claims filing requirements altogether. (Government Code section 946.6).

Appendix D-2

Generally, after one (1) year from the accrual date, the claimant is barred from filing a claim or initiating any lawsuit against the county.

* Information on the Government Tort Claims Act was graciously provided by Santa Barbara County, Risk Management Department.