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Handling Ethical and Moral Dilemmas

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* Official support for the "latest" version of a newly released browser, among those noted above, will be added within 8 weeks of public release. Until then, the previous version will continue to be supported instead.

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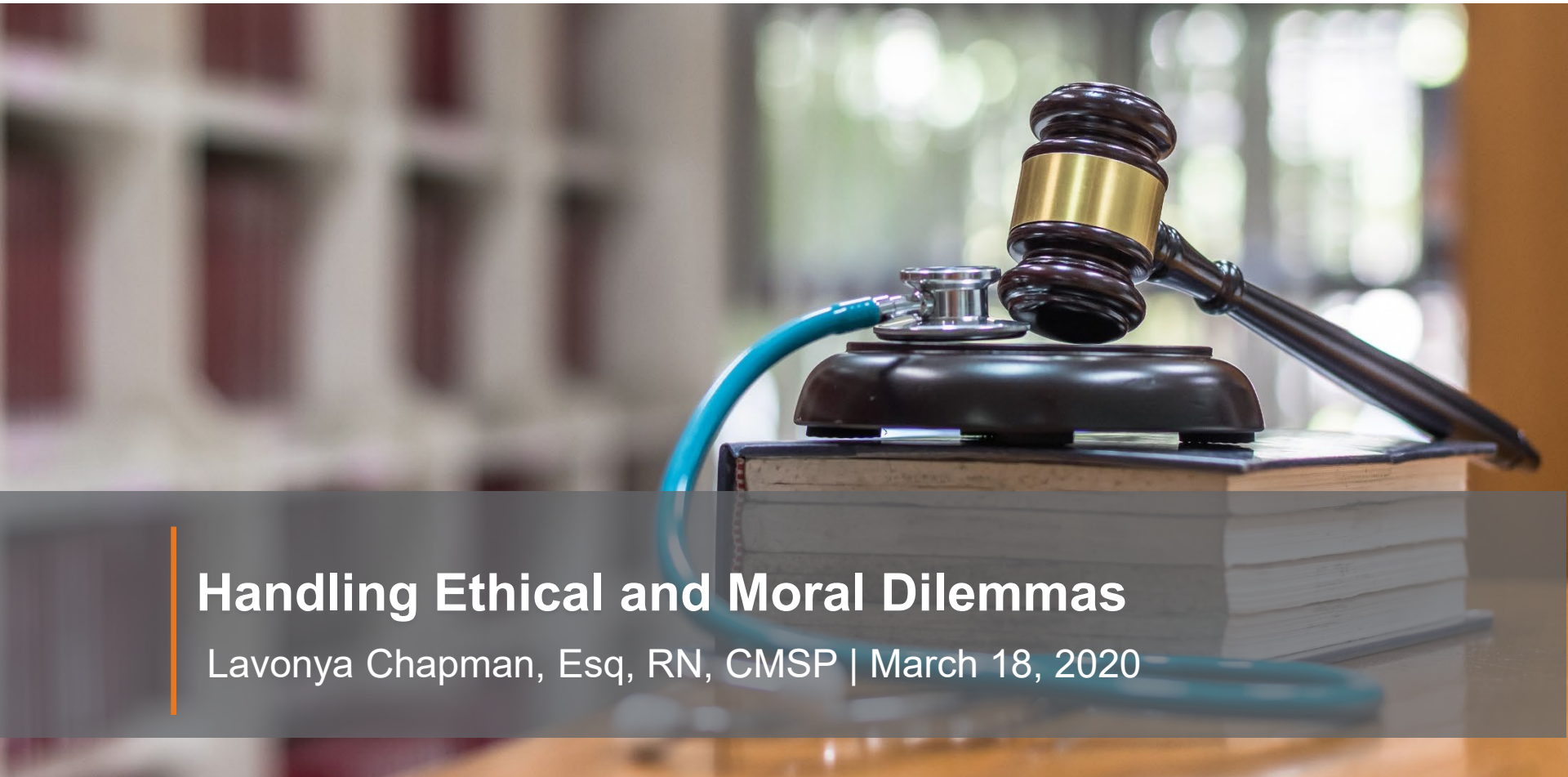

Handling Ethical and Moral Dilemmas

Lavonya Chapman, Esq, RN, CMSP | March 18, 2020

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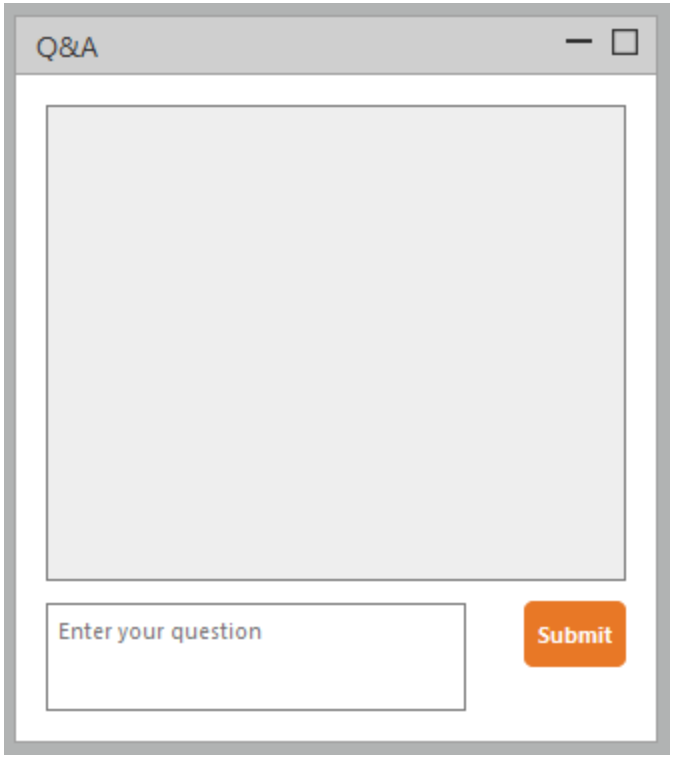

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Today's presenter

Lavonya K Chapman, Esq, RN, CMSP
Medicare Secondary Payer Compliance Counsel
Optum Settlement Solutions

Lavonya Chapman is a member of the management team responsible for strategic planning and product development with legal, regulatory, and compliance oversight of all services provided to include MSP settlement language, Mandatory Insurer Reporting, ICD injury code reporting, Conditional Payment Resolution, Medicare Set-Aside Allocations (MSA), CMS approval, and professional administration of MSAs.

Lavonya joined Optum Settlement Solutions in 2014 as a member of the MSP clinical mitigation team with more than 25 years experience as an attorney, claim director, and registered nurse. Her casualty insurance experience began as a medical case manager at USF&G insurance. Prior to joining Optum, Lavonya served as director of MSP compliance for Arthur J. Gallagher & Company where she started and developed their MSP compliance program from the beginning. She was also the claim director for a new liability captive in which nearly all the claimants/plaintiffs were Medicare beneficiaries or dual eligible.

Additionally, Lavonya has experience in private law practice, litigating medical malpractice, premises, and auto liability claims, as well as workers' compensation cases. As a registered nurse and pharmacology instructor at the University of Alabama at Birmingham, Lavonya is an expert in utilization review and emergency medical services.

Lavonya is a frequent conference speaker and mentor on all aspects of the Medicare Secondary Payer Act as it pertains to claim compliance in the property & casualty industry. She received a Bachelor of Science degree in nursing from the Samford University and a Doctorate of Jurisprudence from Birmingham School of Law.

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Codes of professional conduct govern the duties owed

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Adjuster Code of Ethics – Code of Professional Conduct

An adjuster shall	An adjuster shall NOT
Treat all claimants equally • An adjuster shall not provide favored treatment to any claimant • An adjuster shall adjust all claims strictly in accordance with the insurance contract	Directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or who will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.
Make truthful and unbiased reports of the facts after making a complete investigation.	Approach investigations, adjustments, and settlements in a manner prejudicial to the insured.

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Adjuster Code of Ethics – Code of Professional Conduct

An adjuster shall	An adjuster shall NOT
Handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any compensation or remuneration to himself or herself except that to which he or she is legally entitled.	Negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if the adjuster has knowledge of such representation, except with the consent of the attorney. For purposes of this subsection, the term “third-party claimant” does not include the insured or the insured’s resident relatives.
Act with dispatch and due diligence in achieving a proper disposition of the claim.	Advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel or the employment of a public adjuster to protect the claimant’s interest.

Adjuster Code of Ethics – Code of Professional Conduct

An adjuster shall NOT
Attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss. The adjuster shall not conclude a settlement when the settlement would be disadvantageous to, or to the detriment of, a claimant who is in the traumatic or distressed state described above.
Knowingly fail to advise a claimant of the claimant's claim options in accordance with the terms and conditions of the insurance contract.
Undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.

Adjuster Code of Ethics – Code of Professional Conduct (cont'd)

No person shall, as a company employee adjuster or independent adjuster, represent him or herself or any insurer or independent adjusting firm against any person or entity that the adjuster previously represented as a public adjuster.

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Certified Case Manager
Code of Ethics – Code of Professional Conduct

- Place public interest above their own at all times
- Respect the rights and inherent dignity of all clients
- Maintain objectivity in relationship with clients
- Maintain competency at a level that ensures their clients will receive the highest quality of service
- Obey all laws and regulations
- Maintain the integrity of the Code by responding to request for public comments

https://ccmcertification.org/

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Rehabilitation Providers in Workers' Compensation
Code of Ethics – Code of Professional Conduct

- Vocational Rehabilitation (Maryland)
- Rehabilitation Supplier (Georgia)
- QRC (Minnesota)
- Medical Rehabilitation Nurses (North Carolina)
- ARN - RN License, CRRN, COHN, CRC, CDMS, CCM
- Rehab Counselor Current CRC or CDMS Certification
- Vocational Evaluator – Current CVE Certification

https://rehabnurse.org/

Codes to follow:

- IARP Code of Ethics, Standards of Practice and Competencies
- Code of Professional Conduct of the Certification of Disability Management Specialists Commission
- Code of Professional Conduct of the Association of Rehabilitation Nurses
- The Standards of Practice for Case Managers
- The Code of Professional Conduct for Case Managers

Certified Disability Management Specialists
Code of Ethics – Code of Professional Conduct

1. **Autonomy:** To honor the right to make individual decisions
2. **Beneficence:** To do good to others
3. **Non maleficence:** To do no harm to others
4. **Justice:** To act or treat justly or fairly
5. **Fidelity:** To adhere to fact or detail

https://www.cdms.org/

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Certified Disability Management Specialists
Code of Ethics – Code of Professional Conduct

Certified Disability Management Specialists (CDMS)

CDMS certified individuals recognize that their actions or inactions can either aid or hinder clients in achieving their objectives, and they accept this responsibility as part of their professional obligation. CDMS specialists may be called upon to provide a variety of services and they are obligated to do so in a manner that is consistent with their education, formal training and work experience. In providing services, CDMS specialists must demonstrate their adherence to certain standards. The CDMS Code of Professional Conduct (Code) has been designed to achieve these goals.

https://www.cdms.org/

Code of Ethics – Code of Professional Conduct

- All states have a code of ethics for claim adjusters
- Ethical behavior may be derived from law, institutional practices, professional organizations and codes of conduct
- Many states' codes of ethics are based on Florida's model; Florida's Administrative Code 69B-220.201
- Not only does a violation of the ethical requirements constitute grounds for administrative action against the adjuster licensee, but a breach of any of the ethical requirements constitutes an unfair claims settlement practice.

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Ethical dilemma when claim is not covered under the policy

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Potential conflict of interest from the three party relationship

- Coverage issues can create conflicts of interest since the insurer seeks to limits its obligation to those strictly covered in the policy
- Defense counsel represents, and owes his/her ethical duties to the insured
- Adjuster manages claim for the Insurer
- Nurse case managers, Medicare Set-Aside vendors are retained by the adjuster or third party claims administrator
- Different adjusters may be assigned to handle the claim
  - One for manage coverage and avoidance of bad faith
  - One for managing the litigation of liability, damages, and settlement

Duty owed when claim may not be covered

- The insurer still has a duty to act with good faith in handling that claim
  - Promptly and thoroughly investigate claim and review for coverage
  - Denying a claim within a reasonable time
  - If denying a claim, provide a written explanation of the reasons for the denial
- If coverage is questionable, continue to investigate the claim under a reservation of rights and then withdraw defense at the appropriate time
- File a declaratory judgment to establish non-coverage while defending under reservation of rights
- Settle the underlying cause of action will thereby waive any defense to coverage

Unfair Claims Settlement Practices Act and Bad Faith

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Unfair claims settlement practices and bad faith

- Delays or failure to pay a covered claim
- Insurer misrepresents the policy language, exclusions, endorsements
- Insurer made a significant alteration to an application or policy
- Insurer paying less than reasonably expected

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Unfair claims settlement practices act and bad faith

- Insurance contracts impose a duty of good faith and fair dealing upon the parties
- Standards for investigation and resolution of claims is described in the Unfair Claims Settlement Practices Act (“UCSPA”)
- The UCSPA details practices that are considered to be unfair and can lead to an insured or a third party making a bad faith claim against the insurer
- The standard for evaluating bad faith claims against insurers is whether the insurer acted fairly and honestly toward its insured with due regard for the insured’s interests
- To assert a claim for unfair claims settlement practices, it must first be established that insurance coverage exists

Specific adjuster practices leading to bad faith

- Failing to:
  - Adopt and implement standards for the proper investigation of claims
  - Acknowledge and act promptly upon communications with respect to claims
  - Affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof- of-loss statements have been completed
  - Promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement
  - Promptly notify the insured of any additional information necessary for the processing of a claim
  - Clearly explain the nature of the requested information and the reasons why such information is necessary
  - Pay personal injury protection insurance claims within the time periods required
- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue
- Denying claims without conducting reasonable investigations based upon available information

Bad faith case law

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Bad faith case law

- Determines whether insurers have breached the duty of good faith and fair dealing owed to their insured
- The applicable state "bad faith" law is applied as to whether unfair claims practices and bad faith occurred
- The amount of protection for an insured depends on the causes of action available in the particular state jurisdiction
- Insureds alleging bad faith are protected only to the degree that their jurisdiction chooses to recognize personal claims for bad faith
- The more a state's law specifically defines "improper conduct," the better the insurer clearly understands its duties in handling claims and how to avoid bad faith claims
- The threat of punitive damages or attorneys' fees gives policyholders leverage in insurance coverage disputes

Claim denial due to late notice

Neumayer v. Philadelphia Indem. Ins. Co., — S.E.2d —, 2019 S.C. LEXIS 67, at *17, 2019 WL 3310474 (S.C. July 24, 2019)

Facts	The case involved a motor vehicle accident where a pedestrian, Andrew Neumayer, was struck by a bus driver, resulting in severe injuries necessitating hospitlization. Neumayer filed suit against the bus driver who then failed to answer the complaint, and after eighteen months, the court entered a default judgment in the amount of $622,500.
Issue	Whether an insurer may deny coverage above statutory limits by showing it was *substantially prejudiced*
Outcome	If an insured, (bus driver) fails to give notice to his automobile insurer of a pending claim, the insurer may deny coverage above statutory limits ($25k) upon a showing that it was substantially prejudiced by its insured's failure to comply with the standard notice clause in the policy.

A full and fair investigation

Jordan v. Allstate Insurance Company, 56 148 Cal.App. 4th 1062 (2007)

Facts	The claim involves structural damage where causation was an issue. The insurer failed to do a number of things as part of its investigation, including: retaining an engineer to inspect the property, inspecting the inner walls and subflooring of the home despite potential coverage for hidden decay, interviewing the insured, and interviewing the insured's expert.
Issue	Whether an insurer conducted a proper investigation on which to base denial of the claim.
Outcome	An insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." The court held that "the evidence is undisputed that the insurer failed to properly investigate plaintiff's claim.

Statutory immunity and exclusivity under state workers' compensation laws

Aguilera v. Inservices, Inc., 905 So.2d 84 (Fla., 2005)

Facts	On April 21, 1999, Aguilera was struck by a forklift and pushed against a pallet. He was rushed to the ER where blood was found in his urine. After complaints of bladder pain, his attorney requested an exam by a urologist which was denied as not being work related. After his urine began to smell like feces, another request for a urological consult was made and denied. Shortly thereafter his WC benefits were terminated which blocked the dispensing of his Rx previously prescribed. Again he was denied emergency medical care as not being medical necessary. Eventually, he was diagnosed with a hole in his bladder that created a fistula. Assignment of a new nurse case manager who was not to have direct contact with injured worker, refused to authorize a second opinion. When she appeared in the physician office, she asked the claimant to not disclose that she was present. The nurse case manager insisted the Aguilera submit to invasive tests contraindicated for his condition allegedly as a basis to deny related surgical treatment. She later changed her mind and agreed he needed immediate hospitalization and surgery. Aguilera's ultimate surgery, the need for which had been diagnosed as an emergency as early as June of 1999, was finally authorized or approved on March 22, 2000. Aguilera alleged he had been urinating feces and blood for over ten months.
Issue	Whether WC insurers and adjusters are shielded from liability for outrageous conduct under the statutory immunity provided by the state WC statutes.
Outcome	FL Supreme Count held that intentional tortious conduct caused harm subsequent to and distinct from the original workplace injury and suit may be filed against workers' compensation insurers and adjusters and case managers for the tort of intentional infliction of emotional distress

Does an insurer's duty to settle a claim arise only after an injured/policyholder presents a "valid offer" to settle within policy limits

First Acceptance Insurance Co. of Georgia Inc. v. Hughes, Case No. S18G0517, 2019 WL 1103831, at *1 (Ga. Mar. 11, 2019)

Facts	Auto policyholder caused a multi-car crash killing the policyholder and injuring five others. The policy had the minimum liability limits of $25,000 per person and $50,000 per accident. Two of the injured parties, Julie An and Jina Hong – sent two letters stating their interest in attending a global settlement conference and offered to settle their claims for the available policy limits. As a result of a clerical error, both letters were inadvertently filed away with medical records. When the insurer did not respond to either letter within 30 days, claimants' counsel sent a letter advising the insurer that its offer to settle was rescinded. Insurer continued settlement efforts by inviting claimants to a joint settlement conference with the other claimants, and offering to settle their claims for policy limits. Julie An and Jina Hong rejected the offers. After a 2012 trial, a jury found in favor of the injured parties awarding over $5.3 million dollars in damages to Julie An and Jina Hong . The policyholders' estate then sued Insurer claiming that their failure to settle the claims within the policy limits led to the excess judgment.
Issue	Whether the claimant's presented a "valid offer" to settle within policy limits triggered an insurance carrier's duty to settle
Outcome	The letters presented to the Insurer by the injured parties' counsel was not a time-limited settlement demand. Therefore Insurer's failure to respond before the injured parties withdrew their offer did not constitute negligence or a bad faith failure to settle the claim within policy limits.

Adjuster made reasonable, prompt efforts to settle and was not liable for excess verdict

Calandro v. Sedgwick Claims Management Services, Inc. 2019 WL 1236927, ___ F.3d ___ (2019)

Facts	Genevieve Calandro, a nursing home resident fell from her wheelchair and later died at a hospice facility. Her Estate brought claims against the Radius Nursing Home. Hartford Insurance Company provided $1M in liability coverage to Radius and retained Sedgwick to manage the claim. Sedgwick reported that the cause of death seemed to be related to ongoing medical conditions, not the fall. Although the facility was closing, witnesses had been located and interviewed, but their statements about the incident were inconsistent. Sedgwick made a settlement offer of $250,000 which was rejected and the case went to a four-day trial, resulting in a $14M verdict for wrongful death and conscious pain and suffering, which was far in excess of the Hartford policy limit of $1M.
Issue	Whether the adjuster acted reasonably in its investigation and settlement efforts
Outcome	The Court of Appeals affirmed a decision holding that Sedgwick made reasonable and prompt efforts to settle this nursing home liability claim, and therefore was not liable for the excess verdict. The court observed that Sedgwick had promptly investigated, had engaged an adjuster and defense counsel, had hired a medical expert, and had a reasonable basis for contesting causation.

Ethical applications

- Make a good faith attempt to:
  - Investigate
  - Ascertain causation
  - Review coverage
  - Evaluate claim value
  - Settle the claim
- Insurers, adjusters and agents should endeavor to act in the “utmost of good faith and fair dealing” with their customers
- Professionalism and ethical behavior calls for honest, legal, proper and civil conduct regardless of how poorly a party on the other side behaves
- For claimants who are Medicare beneficiaries, comply with applicable regulations in reporting the settlement, injuries treated and released, to Medicare and confirm that Medicare was reimbursed for conditional payments paid pertaining to the underlying claim

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