Notice Requirements Under Medical Malpractice Policies: How to Lose Your Excess Coverage

Almost all medical malpractice and medical professional liability policies issued today are “claims-made and reported” policies. Under a “claims-made and reported” policy, a medical professional liability claim is covered under the policy in effect when the plaintiff makes a claim to the policyholder and the policyholder reports the claim to the insurer. General liability policies are “occurrence-based,” which means that the policy in effect when the injury occurs responds to the claim. Most health care providers carry not only primary malpractice insurance, but excess malpractice coverage as well. These excess policies are also almost universally issued on a claims-made and reported basis.

Courts around the country are usually very lenient about enforcing notice requirements under occurrence-based policies. In the majority of jurisdictions, New York being one notable exception, an insurer cannot deny coverage based on violation of policy notice requirements unless the late notice materially prejudiced the insurer’s ability to defend or investigate the claim. That is not true for claims-made and reported policies. In case after case around the country, failure to comply with the notice requirements under a claims-made and reported policy voids coverage entirely. A recent Third Circuit case, Lexington Insurance Co. v. Western Pennsylvania Hospital, 423 F.3d 318 (3d Cir. 2005), illustrates how failure to comply with an excess claims-made and reported policy’s notice requirements left a hospital uninsured for a medical malpractice loss. This article will discuss the facts and holdings in Lexington, and will then offer some practical suggestions for avoiding the same result.

The Third Circuit Opinion

Western Pennsylvania Hospital (“West Penn”) had three layers of medical malpractice coverage. The first layer was a primary policy issued by PHICO Insurance Company. The PHICO policy provided both general liability, on an occurrence basis, and medical malpractice coverage on a claims-made and reported basis. The next layer was $1 million worth of excess coverage provided by the Pennsylvania Medical Professional Liability Catastrophe Fund (the “CAT Fund”). Lexington issued an excess policy over those first two layers. The CAT Fund coverage was also on a claims-made and reported basis.
It is important in the field of medical research that research is not only undertaken ethically but that it can also be seen to have been undertaken ethically. This requires a strong regulatory environment.

**Ethics in Stem Cell Research**

In addition to the genetic trait determination, there has been a substantial amount of publicity about the therapeutic potential of stem cells and the ethical use of such techniques. On the one hand, we read of the possibility to clone individuals using stem cells, and on the other, of their potential to cure debilitating diseases—for example, the growth of replacement organs.

One of the leading teams in stem cell therapy was thought to be a group of Korean experts led by Professor Hang Woo-Suk. Recent revelations that his team did not adopt the highest ethical standards in their research and subsequently that they fabricated results have had a severe impact on the reputation of that team. The ethical transgression was that the team had paid women to donate eggs used in the creation of stem cells and in another case the eggs were donated by junior researchers in the team. This is regarded as unethical because it leads to questions of conflict of interest and coercion. It is interesting to note that whilst Korea did not have a regulatory regime until recently, it was the scientific community that raised the concerns about the origin of the embryos. The fabricated results reported by the team led other researchers to review the manner in which they were conducting their research and so has delayed the research of other scientists active in the field.

It is important in the field of medical research that research is not only undertaken ethically but that it can also be seen to have been undertaken ethically. This requires a strong regulatory environment. Whilst it is not possible to cover all the various regimes in one article, readers can find further information in relation to the European framework in the PLC Global Counsel Life Sciences Industry Report 2005/6.

**Differing Regulating Regimes**

In considering the regulatory regimes surrounding stem cells, it is important to bear in mind the origin of the stem cells. If they have been obtained from an embryo, they are often treated differently from adult stem cells. In the UK, the collection of stem cells from embryos is regulated by the HFEA, which was established in 1990 under the Human Fertilisation and Embryology Act 1990 with the primary aim of regulating the use of in-vitro fertilisation. The act was updated in 2001 to...
take account of developments in the field of stem cell research.

The HFEA regulates the creation, use and storage of embryos by a system of granting licences to researchers who are active in the field. This method of regulation should be contrasted with regulation in other countries such as France or Italy, where there are restrictions on such research. In France, for example, it is only permitted to use embryos left over after a fertility treatment and it is not permitted to create embryos specifically for the purpose of research. In Italy, such research is completely prohibited.

It is possible to create stem cells by the use of what is generally referred to as therapeutic cloning through the use of techniques such as cell nuclear replacement. This was the method used to create Dolly, the sheep and has raised important ethical questions about the cloning of human beings. Consequently, there is a greater divergence in the European regulatory regime: France, Germany and Italy, for example, prohibit therapeutic cloning, whereas Sweden, the UK and Belgium permit this practice, subject to the controls of individual regulatory regimes. Reproductive cloning is prohibited under all regulatory regimes referred to above.

The differences in regulatory regimes can be influential when a scientist chooses where to work as well as opportunities to fund companies involved in the development of stem cell technologies. In 2004, Miodrag Stojkovic’s team, based at Newcastle University, was licensed by the HFEA to use therapeutic cloning in its research, and in 2005 the researchers announced that they had successfully created a cloned embryo. Previously, Miodrag Stojkovic had moved his research team from Germany to the UK to take advantage of the relatively permissive regulatory regime.

**The Need for a Unified European Approach**

There is not yet a harmonised regime in the European Community relating to research and therapy using stem cells, but increasingly, there is a need for one. With regard to therapy, there has been a move in this direction with the introduction of a European Directive on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells. This directive aims to ensure that researchers are properly qualified and that proper regulatory authorities are licensing or supervising the activities of such researchers. It also makes provisions relating to the traceability and import and export of such tissues. Further downstream, the European Commission recently adopted a proposal on Advanced Therapy Medicinal Products that would introduce a regulatory framework for treatments involving manipulation of human cells including stem cells (as opposed to simple transplantation). The field of research has not yet seen any comparable initiatives, but the UK legislated in 2004 to establish a regulatory authority and codes of practices governing research on human cells and tissues.

**John Wilkinson**  
George Pickering  
London

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1 Quintavalle (on behalf of Comment on Reproductive Ethics) v Human Fertilisation and Embryology Authority [2005] UKHL 28.  
2 http://crossborder.practicallaw.com/0-201-1704.  
3 Directive 2004/23/EC.  

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A Status Report: Medicare Part B Therapy Caps

The Medicare outpatient therapy caps set forth in Section 1833(g)(1) of the Social Security Act became effective January 1, 2006. These caps place an annual, per beneficiary limit on outpatient therapy services: $1,740 for outpatient physical therapy and speech-language pathology services (combined), and $1,740 on outpatient occupational therapy services. This article discusses the history and implications of the therapy caps, and the exception process created by the Centers for Medicare & Medicaid Services (“CMS”).

**History**

Under Medicare Part B, outpatient therapy services consist of physical therapy, occupational therapy and speech-language pathology. In an ostensible effort to control rising costs and improper payments for outpatient therapy services, Section 4541(c) of the Balanced Budget Act of 1997 established $1,500 therapy caps for non-hospital providers.

The Balanced Budget Refinement Act of 1999 established a two-year moratorium on implementation of the therapy caps. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended the moratorium for an additional year, with the moratorium expiring at the end of 2002. CMS did not implement the therapy caps, however, until September 2003, and they remained in effect from September 1, 2003 to December 7, 2003, when the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reinstated a moratorium on the caps from December 8, 2003 to December 31, 2005. In the Deficit Reduction Act of 2005 (“DRA”), Congress declined to extend the caps, but instructed CMS to create a process for exceptions to the application of the caps. Thus, the therapy caps went into effect January 1, 2006.

**Implications for Providers**

Medicare will apply the therapy caps for dates of service from January 1, 2006 to December 31, 2006, in the order that Medicare receives claims for payment. The limitation applies to the “allowed amount” for services—namely, the amount set forth in the Medicare physician fee schedule (or the amount charged, if less)—minus the coinsurance and any applicable deductible.

Therapy services are provided in a variety of settings—i.e., skilled nursing facilities, hospital outpatient departments, outpatient rehabilitation facilities, and comprehensive outpatient rehabilitation facilities. All Part B outpatient settings, except for emergency rooms and hospital outpatient departments, are subject to the caps. Consequently, beneficiaries can avoid the caps by obtaining services in hospital-based settings. However, it should be noted that Part B therapy services furnished in hospital-based skilled nursing facilities remain subject to the therapy caps.

In addition, the financial limitation is calculated on a per beneficiary basis, not on a provider-specific basis. Therefore, qualified practitioners (e.g., physical therapist, speech-language pathologist, physician) are not limited in the number of patients to whom they may furnish therapy services on an annual basis. Rather, these practitioners are limited in the amount of Medicare-reimbursed therapy service they can provide to a single beneficiary.

With the implementation of the caps, it becomes critical for practitioners...
to determine if patients have already received outpatient therapy services from other providers since the beginning of the calendar year, and whether they have met or exceeded the applicable therapy cap. Providers can then help patients examine their options. For example, a patient may wish to receive therapy services in the practitioner’s outpatient setting and pay out-of-pocket or the patient may wish to receive Medicare-covered services in an outpatient hospital setting.

Exception Process

The DRA requires CMS to implement a procedure where Medicare beneficiaries, providers and suppliers can obtain an exception from the caps for medically necessary therapy. The DRA further provides that, if CMS fails to make a decision about a request for an exception within 10 days, the additional requested services will be considered approved.

In February 2006, CMS established an exceptions process that is retroactive to January 1, 2006. The process provides for two kinds of exceptions—automatic and manual. Automatic exceptions do not require a written request. Certain diagnoses or conditions, evaluation services and clinically complex situations automatically qualify for this type of exception. Conditions that automatically qualify for the exception include multiple sclerosis and osteoarthritis. In order to be covered, services provided above the cap must be medically necessary, covered by Medicare, and documented.

Medically necessary therapy services that exceed the applicable cap but do not qualify for an automatic exception may qualify for a “manual” exception. A beneficiary, provider or supplier can submit a letter requesting up to 15 additional therapy visits to the Medicare contractor reviewing claims. Within 10 business days, the contractor must make a decision as to whether the number of additional treatment days is medically necessary, or the exception will be deemed to be approved for the requested number of visits.

GAO Reviews the Caps

A recent report from the Government Accountability Office ("GAO") ("Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries’ Needs," November 2005) stated that Congress’s reasons for creating the therapy caps still remain—"rising Medicare payments for outpatient therapy and a high rate of improper payments." Therefore, the therapy caps can be seen as a mechanism to help control these problems. However, GAO noted that therapy cap implementation has raised some concerns with patient advocates.

The GAO reports concerns that patients may be adversely affected because the cap acts as a de facto limitation on health care services. The GAO report stated that an analysis of 2002 Medicare claims data from a CMS-contracted study implies that more than half a million beneficiaries receiving therapy in 2002 would have exceeded the caps. The report maintained that it is difficult to tell if these patients would have been adversely affected by application of the caps because the patients may have been able to receive therapy in hospital outpatient departments. Some patients, however, may not have access to therapy in hospital outpatient departments and may not be able to pay for additional therapy. Further, Medicare patients, in particular, may not have the extra funds to pay for therapy out-of-pocket.

Conclusion

Medicare practitioners and beneficiaries will both take some time to adjust to the therapy caps and the exceptions process. The therapy caps may provide a way to control Medicare costs, but they may also adversely affect beneficiary access to therapy services. Given the very recent implementation of the caps, the ultimate impact on all parties remains to be seen.

Kathleen A. Romanow
Washington, D.C.
Facts Before Action, Action Based Upon Facts: Keys To Peer Review Immunity

In August 2004, a federal jury in Texas awarded $366 million to Lawrence R. Poliner, M.D., for a wrongful summary suspension imposed by Presbyterian Hospital of Dallas. On March 27, 2006, the U.S. District Court for the Northern District of Texas ruled in its decision on post-trial motions that there was sufficient evidence to support the jury’s finding that Presbyterian Hospital of Dallas and three physician defendants were not entitled to qualified immunity under the federal Health Care Quality Improvement Act of 1986 (“HCQIA”) or Texas state law. Poliner v. Texas Health Systems, No. Civ.A.3:00-CV-1007-P (Mar. 27, 2006). The court also affirmed the jury’s finding of liability against the defendants for breach of contract, defamation, and tortious interference with business, but reserved ruling on the amount of damages pending mediation. The court’s ruling makes clear to those who participate in peer review that facts are critical and that a summary suspension is not appropriate if imposed to determine whether or not an imminent danger exists.

Immunity Attaches to Peer Review with a Reasonable Factual Basis

HCQIA was passed to help further quality health care through peer review. HCQIA encourages peer review by granting qualified immunity to health care entities taking professional review actions against physicians, provided that certain prerequisites occur. The fundamental prerequisites to immunity under HCQIA are that a professional review action must be taken: (1) in the reasonable belief that the action was in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). HCQIA creates a presumption that a professional review action meets these standards, unless the physician challenging the peer review action rebuts the presumption by a preponderance of the evidence. The question of immunity is often resolved by the court at the summary judgment stage, which precludes the physician from even getting to trial. However, where the physician raises sufficient factual questions to rebut the presumption, the jury can determine whether the four requirements for immunity are met. Like many states, Texas also provides qualified immunity to those participating in professional review actions. The Texas statute provides greater immunity than HCQIA by immunizing any participant in health care peer review who acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts shown. See Tex. Occ. Code § 160.010(a)(2).

Dr. Poliner’s Claims

Between September 1997 and January 1998, three complaints were made about Dr. Poliner’s care of patients in the cardiac catheterization lab and were referred for peer review. On May 12, 1998, while the cases were still under review, a fourth complaint was brought by the Director of the catheterization lab. The Director informed the Cardiology Chief and the Chair of Internal Medicine that

(continued on page 7)
he considered the fourth case to involve a potentially life threatening error. On May 14, 1998, the Chair, the Chief, and the Director, who were all cardiologists, met with Dr. Poliner and requested that he accept an abeyance of his cardiac catheterization privileges until an ad hoc committee could review his cases. Dr. Poliner was given a letter at 2 p.m. and informed that if he did not accept abeyance by 5 p.m., he would be summarily suspended. Under the Hospital’s medical staff bylaws, a summary suspension was justified in cases of “imminent danger” to patient health. Dr. Poliner was not provided information about the fourth patient, was not told which cases would be sent to the ad hoc committee, and was told not to consult with an attorney. Dr. Poliner agreed to the abeyance.

An ad hoc committee later reviewed Dr. Poliner's cases and concluded that substandard care was rendered in 29 of the 44 cases sent for review. Thus, suspension of Dr. Poliner's privileges was recommended. After a subsequent three-day hearing, the hearing committee recommended unanimously that (1) Dr. Poliner's privileges be restored but that (2) the summary suspension had been justified on the evidence known at the time. Further appeal within the Hospital resulted in decisions that Dr. Poliner had been afforded due process and that there was no authority to remove the suspension from Dr. Poliner's record.

Dr. Poliner sued the Hospital, the three physicians involved in the May 14, 1998 meeting (the Director, Chief, and Chair), as well as physicians involved in the ad hoc and other review committees. The court granted summary judgment, based upon HCQIA and Texas statutory immunity, to all of the physicians involved in the peer review actions, except for the three physicians involved in the May 14, 1998 meeting. At trial, the jury awarded Dr. Poliner $366 million in compensatory and punitive damages and answered special interrogatories on the question of immunity. The court's March 27, 2006 order addressed the sufficiency of the evidence to support the jury's determinations on immunity and liability.

**Action in the Absence of Facts Precludes Immunity**

The jury determined that Dr. Poliner overcame the presumption in favor of immunity and that his suspension was not undertaken (1) in the reasonable belief that it furthered quality care, (2) after a reasonable effort to obtain the facts, (3) after adequate notice and hearing procedures, or (4) in the reasonable belief that the suspension was warranted by the facts known. The court identified the following evidence as sufficient to support the jury's special verdicts that the defendants failed to meet any of four prerequisites for immunity under HCQIA:

- the Chair testified that he did not have enough information to assess whether Dr. Poliner posed a danger to his patients at the time he asked Dr. Poliner to agree to the abeyance;
- the Chair threatened Dr. Poliner with suspension of his privileges if Dr. Poliner refused to sign the abeyance letter, although there was no determination at that time that Dr. Poliner was a present threat to his patients—“that is why we asked for an abeyance to investigate it to see if he was in fact
dangerous to his patients”;
- the Chair was prepared to suspend Dr. Poliner’s privileges despite the fact that he did not know whether Dr. Poliner posed a present danger to his patients;
- Dr. Poliner’s expert testified that no reasonable hospital could have taken the action it did against Dr. Poliner except by knowingly or recklessly disregarding the medical evidence;
- the Chair testified that he informed Dr. Poliner that Dr. Poliner must agree to the abeyance of his cardiac catheterization privileges or the Chair would terminate all of his hospital privileges immediately;
- the Chair did not offer Dr. Poliner any other options that may have been less severe;
- the Chair told Dr. Poliner that he was not permitted to consult an attorney;
- the defendants would not discuss the patient cases with Dr. Poliner prior to his summary suspension;
- the defendants did not provide Dr. Poliner with any opportunity to be heard or have a hearing of any kind prior to his summary suspension; and
- the defendants’ “unwillingness” to hear from Dr. Poliner with respect to his patients and his medical treatment of them. The court ruled that the same evidence that defeated HCQIA immunity also supported the jury’s finding of “malice” to defeat immunity under the Texas peer review statute.

The unifying theme underlying these findings is that the defendants took action without sufficient facts and before giving Dr. Poliner an opportunity to respond. The most important issue to the court, which distinguished the participants in the May 14 meeting (who were denied immunity and found liable) from later participants in the peer review process (who were granted immunity and dismissed), was that the May 14 participants acted before they knew the facts, rather than after reasonable efforts to obtain the facts and in reliance on the facts determined. The Chair succinctly stated the problem: “We didn’t determine that Dr. Poliner was a present threat at that particular point. That is why we asked for an abeyance to investigate it to see if he was in fact dangerous to his patients.” The court made no mention of the fact that later peer review participants found errors in 29 of 44 cases they reviewed. The later findings were irrelevant to the May 14 actions. In fact, the later peer review participants were granted immunity, even though their “facts” were later proven “wrong” when their recommendation was reversed and Dr. Poliner was reinstated.

**Action in the Absence of Facts Also Creates Liability**

The court also affirmed liability against the defendants on claims of breach of contract, defamation, and tortious interference with business. On the breach of contract claim, the court focused on the fact that the medical staff bylaws attempted to limit the power of the hospital concerning summary suspension to cases of “imminent danger.” The bylaws also required adequate notice and hearing before disciplinary action could be taken against a physician. Further, under Texas law, the bylaws were enforceable against the Hospital as a contract. Thus, because the defendants did not have a reasonable belief that Dr. Poliner posed an “imminent danger” at the time of the summary suspension, and because the defendants deprived Dr. Poliner of the opportunity to inform the facts before they acted, they breached the bylaws.

On the defamation claim, the defendants argued that they never made any statements about Dr. Poliner. The court rejected this argument and ruled that the defendants “stated” by inference that Dr. Poliner was a dangerous doctor when they summarily suspended him, because the bylaws limit summary suspension to instances of present danger to patients. The court also pointed to instances of third parties being aware of the abeyance and suspension. Moreover, the statement of imminent danger was false because, for example, three of the four cases at issue in the abeyance were months old and could not represent “imminent” danger.

On the tortious interference claim, the court ruled that there was sufficient evidence that the defendants acted with malice towards Dr. Poliner. In particular, they forced him to sign the abeyance letter, suspended his privileges without adequate investigation, and were unwilling to provide Dr. Poliner with an opportunity to be informed or heard on the patient cases at issue.

**Facts before Actions, Actions Based upon Facts**

The Poliner case contains several lessons for those who participate in peer review. First, facts must precede actions to discipline a physician. Concerns or suspected problems are not enough without factual back-up. Second, actions must be based upon facts known at the time after reasonable efforts to obtain the facts. Later-known or discovered facts cannot
The Lexington policy had a pre-printed umbrella form which was occurrence-based for general liability, and had two relevant endorsements. The first, Endorsement 007, provided follow-form claims-made medical malpractice coverage. The follow-form language stated:

Insofar as coverage is available to the Insured in the underlying insurance set forth in the Schedule of Underlying Insurance, this policy applies to liability arising out of medical incidents. All of the terms and conditions of said underlying insurance shall apply to this insuring agreement except as otherwise expressly stated herein.

The underlying insurance identified in the Schedule of Underlying Insurance was the PHICO policy.

Endorsement 001 dealt with a situation unique to Pennsylvania medical malpractice coverage, i.e., that the Pennsylvania CAT Fund statute required the CAT Fund to become primary insurance for any claim made more than four years after a medical incident. These claims, called 605 claims, were not covered at all by primary insurance no matter when the claim was reported. The specific language of Endorsement 001 provided:

In the event underlying insurance shall not be applicable to any claim for the reason that the [CAT] Fund shall assume or be required to assume primary responsibility for payment..., coverage under this policy as to such claim shall apply as excess immediately over the limit of liability of the [CAT] Fund.

The Liebs filed the underlying malpractice action on May 25, 2001, alleging that malpractice had occurred in 1990, when the Lieb's daughter was injured because of delay in performing a Caesarean section. West Penn timely submitted a notice of claim to PHICO, which referred the matter to the CAT Fund as a 605 claim. The Lexington policy was in effect on the date that the Lieb claim was served on West Penn and during the policy period when notice was given to PHICO and the CAT Fund. Lexington claimed that West Penn did not give notice of the Lieb claim until February 12, 2003, long after the Lexington policy in effect when the claim was made expired. After Lexington denied coverage, the Liebs and West Penn entered into a high-low agreement before trial, and West Penn ended up paying the Liebs an agreed amount. West Penn's primary argument was that Endorsement 007's follow-form provision did not apply to the Lieb claim because the CAT Fund substituted for PHICO under Endorsement 001. West Penn contended that Endorsement 007's follow-form coverage only applied where the underlying medical malpractice claim was covered by the primary PHICO policy. According to West Penn, since the CAT Fund assumed responsibility for the Lieb claim, the PHICO coverage was not "available" and, therefore, Endorsement 007's follow-form claims-made and reported requirement did not apply. As a result, West Penn argued, the Lexington policy's pre-printed occurrence-based notice provision applied and, under Pennsylvania law, a current failure to comply with an occurrence-based notice provision does not preclude coverage unless the insurer was prejudiced by the late notice. Lexington did not claim prejudice because of the late notice.

The Third Circuit disagreed, holding that Endorsement 007 clearly provided claims-made coverage and required that any exceptions to the follow-form nature of the claims-made coverage had to be expressly stated. The court did not find Endorsements 001 and 007 mutually exclusive and read them as complimentary. The court acknowledged that "it would strain both logic and insurance industry practice to extend" the occurrence-based notice provision to 605 claims.

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"Notice Requirements Under Medical Malpractice Policies: Losing Your Excess Coverage" – cont'd from page 1

Keith T. Shiner
Falls Church
when 605 claims were by their nature claims-made. West Penn's theory required the court to apply an occurrence-based notice provision to a claims-made coverage. The court acknowledged the important differences between claims-made and occurrence-based coverage. The majority recognized that West Penn's theory would expand the coverage to give West Penn the best of both occurrence and claims-made coverage so that it would have coverage for claims that occurred before the policy incepted, but were neither made nor reported during the policy period.

The majority rejected the hospital's argument that Endorsement 007 did not apply because medical professional liability coverage was not "available" to the hospital. Judge Becker, writing for a majority of the panel, explained that medical liability coverage under the PHICO policy was "available" to the hospital, satisfying Endorsement 007, even though it was not "applicable" to the Lieb claim. Judge Becker recognized that the same situation exists where "available" liability coverage does not "apply" to a particular claim if the insured intended the injury or engaged in a criminal act.

West Penn also argued that an excess insurer must prove prejudice in order to enforce a claims-made and reported requirement, and thereby deny coverage based on late notice. Although the lack of prejudice requirement under a claims-made policy has been the subject of numerous decisions of federal district courts in Pennsylvania, neither the Third Circuit nor the Pennsylvania Supreme Court had addressed the issue in the context of an excess claims-made policy. The majority opinion also spent some time addressing West Penn's contention that there was a factual issue as to whether Lexington had notice of the Lieb claim within the policy period. Although West Penn had given notice of 23 separate claims on the last day of the Lexington policy period, the Lieb claim was not among them. Instead, West Penn argued that the Lieb claim would have come up on loss runs and was reflected in an internal Lexington document. After ruling that the internal document was both authentic and the information on which West Penn relied was not hearsay, the majority opinion held that the document was insufficient to raise a genuine material issue of fact. In addition, the testimony of West Penn's Assistant General Counsel was also insufficient to raise a genuine issue of material fact because she did not have actual knowledge that the claim had been discussed with Lexington, but was merely speculating that it "would have been" or "should have been" discussed.

Avoiding the West Penn Problem
West Penn clearly knew it was required to report claims to its primary and excess malpractice carriers during the policy period in which they were received. In fact, as discussed above,
West Penn actually reported 23 other claims to Lexington on the last day of the policy period. It simply failed to report the Lieb claim. Health care providers can avoid this type of unfortunate result with some simple precautions:

- Require all claims to be reported to a specific person who understands that the report is for purposes of giving prompt notice to insurers and knows what notice requirements are imposed by the policies. In the case of corporate policyholders, that person should be either the general counsel or the risk manager. In the case of individual health care providers or small groups, a designated administrator or professional should be identified.

- The designated person should create a log of all claims, noting the date each claim was received and the date it was reported to the insurer. Many policies have very specific requirements of how to report claims, including reporting them in writing to specific addresses. Failure to follow those instructions, including reporting orally when written notice is required, can void coverage. If reporting through a broker, insist on a copy of the broker’s letter to the insurer and indicate on the log when that letter was sent. If you are close to the end of the policy period, report the claim with a copy to the broker. Copies of all relevant documents should be retained with the log.

- Claims must be reported to all insurers, not just primary insurers. Because reporting a claim is an element of coverage in claims-made policies, the insured must provide separate reporting to an excess carrier that issued a claims-made and reported policy.

Following these simple procedures insures that claims are timely reported, protecting coverage.

Jay Levin
Philadelphia

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For those attending the AHLA Annual Meeting, trolley transportation will be offered from the Philadelphia Marriott Downtown, 1201 Market Street, beginning at 6:45 p.m. and will be making periodic returns to the hotel.

*The Mutter Museum was founded to educate future doctors about anatomy and human medical anomalies. Today, it serves as a valuable resource for educating and enlightening the public about our medical past and for telling important stories about what it means to be human.
Keith Shiner was elected to the Board of the Northern Virginia Area Health Education Center in December 2005. He was also elected to the Board of the Arlington Free Clinic in January 2006.

Robert J. Hill authored the cover article for the January issue of AHLA Health Lawyers News, entitled “Medicare Part D and Long Term Care: Confusion and Complaints Mark Transition to New Drug Coverage.”

Karl A. Thallner wrote an article entitled “Government Seeks to Encourage e-Prescribing,” which discusses the proposed Stark exception and Anti-Kickback Safe Harbor for electronic prescribing and electronic health records technologies, which was published in the January 2006 issue of Physician’s News Digest.

In February 2006, Daniel A. Cody gave two presentations at the American Bar Association Health Law Section’s “Emerging Issues in Healthcare Law 2006” conference in Tucson, Arizona. The first was entitled “Medicare and Medicaid Reimbursement” as part of a panel discussion on “Fundamentals for Health Lawyers.” The second presentation was entitled “The New Medicare Appeals Process—A Report From the Field.”


Tracy L. Acker presented “Clarifying the Role of the Medical Science Liaison with Respect to Off-Label Uses” on April 24, 2006 at the 2nd National Pharmaceutical & Medical Device Counsel’s Guide to Off-Label Communications Conference.

Elizabeth Carder-Thompson chaired the American Health Lawyers Association’s Life Sciences Law Institute from April 30–May 2, 2006 and spoke on the topic of “Coverage, Reimbursement, and Fraud and Abuse Basics.” Robert J. Kaufman assisted with preparation of the program materials.

Thomas W. Greeson’s “Utilization Rules Should Target Self-Referral” appeared in the March 2006 issue of DIAGNOSTIC IMAGING, and he was quoted on AuntMinnie.com regarding Medicare Physician Fee Schedule in March 2006. His speaking engagements included “Update on Regulatory Issues Facing Radiologists” at the Medical Management Professionals 2006 Management Meeting in February 2006; “What You Need to Know About the Medicare Rules to Form Joint Ventures and Other Arrangements—Part I and Part II” at the Educational Symposia’s Cardiovascular Imaging Symposium in March 2006; “Legal Perspectives—Challenges and Options—Updated for 2006” at RCG Healthcare Consulting Imaging Center Symposium in March 2006; and “Joint Ventures and Other Hot Compliance Issues,” “Outside Reading Arrangements that Won’t Break the Rules,” “Reassignment, Purchased Interpretations and Overreads,” and “Contracts Between Radiology Groups and Their Hospitals,” presented at the Educational Symposia Spring Economics Summit in April 2006.

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<td>2/16/06</td>
<td>Deficit Reduction Act Enacted with Major Medicare and Medicaid Provisions</td>
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<tr>
<td>4/4/06</td>
<td>OIG Advisory Opinion 06-02: Management Services Arrangements Between DME Suppliers and Physicians</td>
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<tr>
<td>4/24/06</td>
<td>CMS Proposes Major Reforms of Medicare Inpatient Hospital Payment System and Changes for Long-Term Care Hospital Payments</td>
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<tr>
<td>5/22/06</td>
<td>CMS Issues Proposed Rule to Implement Medicare Competitive Bidding Program &amp; Other Payment Reforms for Durable Medical Equipment, Prosthetics, Orthotics, &amp; Supplies</td>
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<td>5/22/06</td>
<td>CMS Issues Fraud Provider/Supplier Enrollment Rule</td>
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If you would like copies of any of the above-listed memoranda, please contact a member of our Health Care Group and they will be happy to send them to you.