HMO And Malpractice

Health Maintenance Organizations work closely with patients to connect them to providers who can provide the care they need. In return the HMO receives a set payment with is arranged with the insurance company. Providers must apply to be in the network. For a provider to become an in-network provider they must have specific credentials to prove the quality of care will be met. This assures providers meet the care requirements and are less likely to have malpractice issues, however should they run into issues they must have malpractice insurance to cover them. HMO's vet potential providers before approving them to be in-network due to the liabilities that can fall on the HMO for approving that provider. (DiCicco, 1998)HMO's help reduce unnecessary emergency and specialists visits by requiring a referral from their primary care physician. This cuts costs and delegates patients to the proper providers; however, it can be difficult for patients who require care in a quicker manner than they are able to obtain due to the referral process. Assigning, receiving, and processing referrals can be a time-consuming process for larger practices which can cause strain on staff members as well as patients whom are waiting for the referrals to seek further treatment. (Steele, 2013).

An example of this process causing medical crisis' for patients and malpractice suits against provider is the 1988, Boyd v. Albert Einstein Medical Center case. A patient needed a biopsy done and upon receiving the testing she was injured further which continued to get worse. Being that she had an HMO she returned to the primary provider she originally received a referral from, but it was not enough. This patient needed emergency care which the provider did not refer her to. Instead she received testing which would take days to receive results on. Had she been transferred to the emergency room, she could have had her test results sooner and possibly a different health outcome. The patient lost her life due to the negligence of the provider performing the tests knowing results would not be timely. (Hall, & Orentlicher, 2013, p. 129). HMO's must watch their referral and refusal actions carefully, to not risk an HMO negligence case. Reasons these cases can be brought up are:

- Denying necessary diagnostics in life threatening cases
- Reusing referral requests which are necessary (including to providers outside of the network, when necessary)
- Refusing to transfer a patient to another facility when needed (if the current facility cannot provider required diagnostics or treatments)
- Refusal to seek second opinions from outside providers when an in-network provider is not enough

There is the possibility of lawsuits against the HMO in these situations can be malpractice by

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doctor, wrongful death due to the denial to specific needed services and resulting in the loss of a patient's life, as well as bad faith suits for denying claims which should have been paid without issue. An insurance company cannot deny routine covered services without reason. Legitimate reason must be given for every denied claim. Services considered non-medically necessary may not be covered or may require authorization. An example is acupuncture with is considered alternative medicine and not proven necessary. Plastic surgery is not covered unless deemed medically necessary and authorized by the HMO. (Sterodimas, Radwanski, & Pitanguy, 2011).

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