Back to the Basics: The Importance of Good Communication and Documentation in a Complex Case

By Stephanie Walkley, JD, BSN

Tony Green[1], a 29-year-old construction worker, presented to the emergency department of a small, regional hospital complaining of lower and upper back pain over two days after lifting some flooring at a worksite. He described the pain as worsening with movement and radiating through to his chest. He was able to move all of his extremities, had full range of motion, and walked with a normal gait. The emergency room provider diagnosed Mr. Green with muscle strain and discharged him home with prescriptions for a muscle relaxer and pain medication.

Two days later Mr. Green woke up with severe pain in his neck, back, and chest. He also had weakness in his right leg. Within a few hours of waking, he could not move his right leg so he called 911. EMS transported Mr. Green to the hospital emergency department where he had been seen only a couple of days earlier. On arrival, he had profound weakness in both of his legs and was unable to stand. The nurse triage record indicates Mr. Green was able to wiggle his toes but could not otherwise move his lower extremities. The emergency room provider admitted Mr. Green and ordered a neurology consult.

Dr. Mark Hanson, neurologist, arrived to see Mr. Green approximately five hours later. By the time Dr. Hanson arrived and examined Mr. Green, Mr. Green could no longer move his toes and could not feel touch on either extremity. He denied any bladder or bowel problems. He could feel touch at the T12 level and above. Dr. Hanson ordered a STAT MRI of the lumbar and lower thoracic spine.

Within the hour, a MRI of the thoracic and lumbar spine was completed. Dr. Seth Grant, radiologist, read the MRI off site in the middle of the night. He completed a preliminary report, which indicated lumbar degeneration with a minimal annular bulge at L5-S1 and a normal thoracic spine.

Relying on the preliminary report, which ruled out compression of the spinal cord, Dr. Hanson made no attempt to transfer Mr. Green to a facility with neurosurgical coverage. Given the MRI results, Dr. Hanson's differential diagnosis now included cancer, intrinsic lesion within the cord not seen on MRI, and transverse myelitis. Dr. Hanson ordered a battery of tests, including lumbar puncture and MRI of the cervical spine, to determine what non-compressive problem could be causing Mr. Green's symptoms.

The following day, Mr. Green began having urinary problems and could not void. Dr. Hanson continued with his differential diagnosis of a non-compressive condition. Dr. Grant came to the hospital and reviewed all of the films from the night before. When he looked at Mr. Green's MRI, he noticed issues that he did not appreciate on his initial read. Dr. Grant saw a possible acute epidural hematoma from T7 through T11, causing moderate mass effect on the spinal cord. He recommended further evaluation.

Dr. Grant dictated a final report but made no attempt to call Dr. Hanson or Mr. Green's nurse to alert them of his findings. Instead Dr. Grant dictated his final report and relied on the hospital's notification system to fax the final report to Dr. Hanson's office and the nurses' station. The final report was not transcribed and faxed until the next day. The final report was also uploaded to the hospital's EMR system. However, Dr. Hanson did not learn of Dr. Grant's findings from the final report for another day. In total, more than 60 hours had passed since the MRI before Dr. Hanson knew of the correct results.

When Dr. Hanson learned of the findings from the MRI final report, he immediately tried to find a facility and neurosurgeon willing to accept the patient for transfer. After a couple of failed attempts, Dr. Hanson found a facility and neurosurgeon in a major metropolitan area approximately 50 miles away to assume care of the patient. Arranging the logistics of the transfer took time. The patient had been in the hospital more than 72 hours before he was finally transferred to his new facility. Once the transfer occurred, Dr. Hanson made no effort to find out about the patient's prognosis or outcome.

We now know that Mr. Green did indeed suffer from a hematoma at multiple thoracic levels. After arriving at the accepting facility, he underwent an emergent thoracic laminectomy for decompression. Despite the neurosurgical care and treatment, Mr. Green did not recover sensation or function below the waist. He now requires the use of a wheelchair and is incontinent of bladder and bowel.

Mr. Green filed suit against Dr. Hanson, Dr. Grant, and the hospital. The hospital settled for an undisclosed amount shortly after the suit was filed. After the hospital was dismissed, Dr. Hanson and Dr. Grant remained in the lawsuit.

The primary criticisms in the lawsuit related to Dr. Grant. He clearly missed the compression on the initial read of the MRI. Although no one knows if the ultimate outcome could have been different, Dr. Grant had the opportunity to mitigate his mistake. When he did his final read the day after the MRI, he should have done more than rely on the hospital's automated reporting system.

Once he noticed the compression lesion on the MRI, Dr. Grant should have been more proactive in making sure the ordering physician, Dr. Hanson, knew about it. Time is of the essence with this type of finding, and Dr. Grant's approach to his reporting and communication duties was indefensible. [2] Dr. Grant negotiated a settlement with Mr. Green not long after the hospital finalized its settlement.

Dr. Hanson remained in the lawsuit as the sole defendant. He felt very strongly that he should defend the lawsuit and not entertain any settlement negotiations. He relied on Dr. Grant's interpretation and preliminary report. Likewise, he relied on Dr. Grant and the hospital to apprise him of any changes in interpretation or emergent findings.

Defense counsel for Dr. Hanson had the case reviewed and located two neurologists who supported his care. However, of note, Dr. Hanson's defense was not without its problems. His history and physical lacked detail, particularly with regards to the neurological exam. Dr. Hanson did not dictate the history and physical, or the discharge summary, until six months after his treatment of Mr. Green. Furthermore, some of the information in Dr. Hanson's history and physical was inconsistent with his progress notes from Mr. Green's hospitalization.

The case proceeded to a jury trial. Ultimately, the jury returned a verdict in favor of Mr. Green. Mr. Green's experts successfully persuaded the jury that Dr. Hanson had a duty to look at the films himself and call the radiologist. The jurors also took issue with the fact that there was such a significant time lapse with Dr. Hanson's dictation as well as the discrepancies in his charting. The jury felt the charting issues hurt Dr. Hanson's credibility and bolstered the allegations that he was less than diligent with his care.

There are many lessons to be learned from this unfortunate case. The primary takeaway can be condensed into two words—communicate and document. Patient safety and outcomes often depend upon good communication and documentation. Not every negative outcome can be prevented or avoided, but a negative outcome should not be a result of poor communication or documentation.

Although Dr. Grant initially misread the MRI, he caught his mistake. Rather than picking up the phone to alert Dr. Hanson or Mr. Green's nurse of the emergent finding, he relied on the hospital's routine reporting system. There should have been immediate action by Dr. Grant to ensure the ordering physician, Dr. Hanson, knew about his final read. The lack of communication resulted in a tragic outcome.

Finally, the importance of complete, accurate, and contemporaneous documentation

cannot be overstated. In order for the healthcare team to provide good care, everyone on the team should be writing, typing, or dictating their notes in a timely fashion. The information should be clear and concise. As illustrated above, poor documentation can impair the defense of a claim. Although the primary purpose of documentation is to facilitate good communication among providers and continuity of care, when there are poor outcomes, documentation often becomes the main focus of litigation. Be sure that your records accurately reflect the care and treatment.

[1]The names of the patient and physicians have been changed.

[2] While clinical practice guidelines do not set the legal standard of care and each case is fact-dependent, the American College of Radiology Guidelines may be found at here.

Addressing Juror Expectations in Everyday Practice: MEDIC

By Jill Huntley Taylor, Ph.D

Dr. Taylor is a contributor to this year's Risk Education seminar "A Jury's Perspective - The Good, The Bad, The Ugly"

As a trial consultant, I am involved in conducting mock trials in all types of cases, including medical malpractice cases. In each case, I am looking for the problems and opportunities to help the team develop the best strategies for the case with the goal of prevailing at trial.

In addition to the case-specific work, I am always listening to the mock jurors and paying careful attention to trends based on what they say about the case and the parties. I pay close attention to what upsets mock jurors, which often centers on how a patient was treated, or how that treatment was communicated to the patient and in the medical record. I share what I learn from these mock jurors with medical professionals and the lawyers trying these types of cases so that they can better understand jurors' expectations. Lessons may be learned about what a healthcare provider can do proactively to avoid litigation in the first instance.

I've boiled these lessons down into the acronym MEDIC. It's a very simple, hopefully memorable, acronym of the expectations that jurors have in medical malpractice cases.

The "M" is for medicine; "E" for education, "D" for documentation, "I" for informed consent; and "C" for caring. The following breaks down each component of MEDIC.

Medicine

Let's start with medicine. In a medical malpractice case, it seems all things should begin and end with the medicine, i.e. did the medical professional meet the standard of care?

If a case actually gets to trial, whether or not the standard of care was met will be in dispute. There will be an expert on the plaintiff side and an expert on the defense side, which amounts to a “battle of the experts” in the minds of jurors. Additionally, the medicine is complex from a juror's standpoint, so they very often turn to other elements to evaluate the provided care. While the medicine matters, part of the assessment of the medicine for jurors is asking themselves, “what do I think about this medical professional?Do I trust this medical professional? Is this someone that I would want to go to or want my family to go to?” This is where all other expectations come into play, and are the important components that jurors understand and gravitate toward when answering those questions.

Education

After the medicine, is education. In the context of medical malpractice litigation, education is really about communication - communication to the patient about their medical condition and treatment plan, and communication within a medical practice. The more you inform a patient about the aspects of their medical care, the more likely the patient will become an active participant in that care.

Medical professionals are the experts. They have greater knowledge than a patient. But, jurors want to see that a patient was informed and was given information from the moment they meet with the medical team through their treatment and then their follow-up care. This empowers the patient, which is important to the defense of a medical malpractice case. Jurors want to know that the patient, or the family of the patient, actively participated in his or her care, made informed decisions about that care, and had the opportunity to ask questions of their provider. At trial, an empowered patient reduces jurors' motivations to take care of a plaintiff/patient who has been harmed in some way.

By way of an example, consider a mother who was a very vigilant parent and took her child for all of his well-care visits. She was an active participant in her son’s care. When the family filed a lawsuit against the treating pediatrician alleging failure to diagnose, their lawyer attempted to argue that the family trusted this doctor and the doctor breached the plaintiff/patient's trust. But an examination of the record supported the argument that the doctor provided good, conscientious care based upon detailed documentation that included conversations with the parents, observations associated with physical examinations, and numerous referrals to specialists when needed.

Additionally, the mother requested the same doctor every time she brought the child to the office. Based upon all of the evidence, the defendant physician’s attorney argued that the mother did indeed trust this doctor, and she was armed with all pertinent information that allowed her to actively participate in her child’s care. Further, it was argued that if she felt that there was bad care, she would have gone elsewhere. In this situation, the vigilant, empowered patient is a much better plaintiff for the defense than the patient who doesn't play an active role in his care and who doesn't know what his care entails.

On the other side of the coin, we have seen situations where the patient was not informed

to the point of angering the jury. For example, consider a surgical complication case where, in the process of trying to remove a tumor, the surgeon cut into the pancreas. It was not a medical error, but rather a complication of how the tumor was situated. The complication itself did not upset the jurors at the mock trial. Instead, the jurors were upset about the failure to adequately educate the patient about what happened post-surgery.

In this case, jurors believed that the patient did not have a clear understanding of what happened during the surgery or how he should care for and monitor the complication during the recovery process. Jurors were focused on the failed communication, rather than any failure in the medicine. Good communication and good education can empower a patient/plaintiff. On the other hand, failures in communication can give jurors the motivation to find against the medical provider, even when the jurors are not particularly critical of the medicine.

Documentation

Jurors look for evidence of both communication and medical care in the medical documentation.

Time and time again, documentation is raised as an issue in medical malpractice cases. Jurors often believe if it's not in the record, it did not happen. They have very high expectations for medical documentation. Most are unwilling to take doctors and other medical staff (or anyone) at their word, but do tend to rely heavily on what was documented contemporaneously.

The expectation for clear and thorough documentation includes documenting conversations and information provided to the patient and the patient's family. Without such documentation, whether the patient was well informed is simply a matter of he-said, she-said.

Because documentation is evidence, what is not documented is as important as what is documented. Just as jurors have a difficult time believing something happened if it is not documented, anything that is documented can take on a life of its own at trial.

Such documented evidence can be put up in front of a jury for their study and scrutiny. This is especially troublesome in cases of inappropriate documentation. Noting opinions in the medical records, particularly unflattering opinions of patients, staff, or other doctors, is likely to be problematic at trial. Factual and objective documentation of the medical care is key.

Thoughtful and thorough documentation can greatly help in the defense of a case. Going back to the example of the mother who was vigilant about her child's care, the documentation in that case not only empowered the mother as an active participant in the eyes of the jury, but it supported the defense position that the doctor provided attentive and conscientious care.

One of the plaintiff's allegations in that case was that the doctor was simply electronically checking boxes as a matter of routine without really doing her job as a doctor. We asked to look at the electronic medical records more closely and when examining the documentation, we found that the doctor had documented numerous conversations with the mother along with medical observations made during her examinations of the infant patient and referrals made to outside specialists.

That documentation not only showed what the doctor did, but also that the doctor took time with her patient, was attentive, and she cared. The documentation really helped the mock jurors understand what kind of a doctor she is. Was this a doctor who just checks boxes, or was this a doctor who cares? Documentation in that case was critical.

Informed Consent

One specific aspect of communication to which jurors pay very close attention is the informed consent process. Jurors want the patient to be informed about what the medical treatment entails and what to expect, including potential side effects and complications. Remember - an informed patient is an empowered patient.

Establishing that a patient has been properly informed may help with legal defenses as well as with portraying the doctor and staff as educating and caring providers.

Establishing good informed consent is abundantly easier if the process is well documented. A thorough note in the chart or a signed consent form can make all the difference in a medical malpractice case. Going a step further, jurors want to know that the information given was understandable to the patient and that the patient had the opportunity to ask questions and discuss it with the medical team. A medical team that takes the time to explain the medicine to the patient demonstrates that they care.

Caring

When evaluating what happened in a medical malpractice case, jurors are looking for evidence that will help them answer the ultimate question - did this medical professional care? The vast majority of jurors believe that medical professionals go into the medical field to help and heal people because they care.

From the moment they met the patient, through the entire course of treatment, jurors are looking for evidence that the medical professional cared about the patient. If the situation results in litigation, jurors will also be evaluating how caring the medical professional is based on how they come across in their deposition, as well as on the witness stand when they are testifying in court. Even the manner in which the medical professional handles him/herself in and around the courthouse factors into whether the jurors believe this is a caring medical professional.

Jurors take all the information that they can gather about that professional and determine, "is this someone I would want caring for me? Is this someone I would want caring for my

family member?”

Jurors also evaluate how caring the medical professional is based on how they respond to adverse outcomes. A provider who promptly and honestly discusses the adverse event with the patient and family, shows empathy for the difficult situation, takes appropriate action to deal with the situation, and keeps the family informed is viewed as caring by jurors. Contrast that with a provider who was evasive and defensive in the event of an adverse outcome. Such provider is not viewed favorably and, in fact, can incite anger in jurors. Anger, in turn, is what can drive and motivate jurors to find against the defendant provider. Jurors understand that there can be bad outcomes associated with medical care, but they are unforgiving when a healthcare professional responds in an uncaring manner.

At the end of the day, the medicine is important but will be debated by the experts. Jurors do not know the medicine, but they do know people and they want to know that the doctor and the staff cared about the patient in the case. If the treatment resulted in a lawsuit, obviously there was a negative outcome of some sort. The difference between a good, bad and an ugly verdict can come down to how the jurors feel about the patient/plaintiff’s care. Following the principles outlined in MEDIC will help ensure that jurors will have a positive feeling about the patient’s care.

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Physician Burnout: What Is It and What Causes It?

By Michael Baron, MD, MPH, FASAM

Editor's Note: This is part two in a four-part series on physician burnout. Part one was published in the January 2018 edition of The SVMIC Sentinel, available here. Part three in this series will be published in our July edition.

A physician touches the lives of many people, including his family, friends, colleagues, and patients. Their death affects those same people. In part one of this four-part series we saw how that was true for Dr. W. Unbeknownst to anyone, Dr. W.'s burnout evolved into a severe depression. Soon afterward, his life ended by a completed suicide. The suffering that Dr. W. quietly endured must have been considerable for him to even consider suicide, let alone complete the act. Dr. W's family lost a husband, father, and provider; his friends lost a confidant, and his patients lost their physician. Although burnout doesn't generally end in suicide, it does cause significant personal and professional loss for the physician.

In this second article, we will take a much closer look at physician burnout, which is associated with real suffering among physicians who are themselves dedicated to relieving suffering.

Physician burnout is associated with an increased risk for the development of substance use disorders and an even greater risk of suicidal ideation. On the professional side, physician burnout is a risk factor for an increased probability of making a medical error and being involved in a malpractice suit. Patient mortality rates in an ICU setting and healthcare-associated infections are negatively influenced by burnout symptoms, as are patient satisfaction scores and patient adherence to medical advice. A physician experiencing burnout is more likely to leave his current practice or give a reduced professional effort, resulting in loss of productivity. There is also an increase in patient referrals and the ordering of tests by physicians with burnout. The personal and professional consequences of physician burnout lead to increased healthcare costs and decreased quality of patient care.

Burnout Defined

Burnout was first described in the 1970s as a state of fatigue or frustration resulting from professional relationships that failed to produce expected rewards (Freudenberger, 1974). A few years later that definition was expanded to be a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal

accomplishment that occurs among various professionals who work with other people in challenging situations (Maslach, 1982). Christina Maslach went on to describe burnout as "an erosion of the soul caused by a deterioration of one's values, dignity, spirit, and will." (Maslach C, Leiter MP. The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It. San Francisco: Jossey-Bass; 1997.)

Physician burnout is a work-related syndrome, primarily driven by workplace stressors, consisting of three major areas: Emotional Exhaustion, Depersonalization, and Low Personal Achievement.

1. Emotional exhaustion is characterized by losing enthusiasm for work. The physician's physical and emotional energy levels are almost depleted and are continuing to drain.
2. Depersonalization is treating people without empathy, as if they were objects. Cynicism, sarcasm, and the need to vent about your patients is evidence of this element. This is commonly called "compassion fatigue" or "caregiver syndrome." The physician is not emotionally available to anyone, including their own significant others.
3. Having a sense that work is no longer meaningful describes low personal achievement. The physician feels like his or her work doesn't really matter or serve a purpose. They doubt the meaning or significance of their work. They are aware that they may make an error because they don't have the intensity to perform at their highest level.

Numerous studies that have included nearly every medical and surgical specialty show that physician burnout symptoms have reached epidemic levels – several national studies cite a prevalence exceeding 50 percent. Unfortunately, the statistics continue to get worse as burnout rates continue to increase. As expected, physicians working in the trenches or on the front lines of medical care are among those with the highest risk. Those specialties include Emergency Medicine, Family Medicine, Internal Medicine and Neurology.

We can also view physician burnout as a metaphor: the physician was very committed to his work but then the fire or enthusiasm went out. This would infer that burnout can only happen following a high level of intensity, engagement, or interest in work. A physician cannot practice without a high level of intensity. This metaphor also insinuates that to prevent burnout, the fire must keep burning. Fires won't burn without the required resources; a fuel source in the presence of oxygen. Physician burnout occurs when resources are inadequate to feed the physician's emotional and physical fire.

Burnout Causes

The causes of physician burnout are complex. The organization and the practice environment the physician participates in plays a critical role. The drivers of burnout can be grouped into seven dimensions: workload; efficiency; flexibility/control over work; work-life integration; alignment of individual and organizational values; social support/community at work; and the degree of meaning derived from work (Mayo Clin Pro,

10:4; 1-18, 2016). Each of these drivers is influenced by individual physician factors, work unit factors, organizational factors, and national factors.

Individual Factors

The individual physician factors driving burnout are related to specialty, practice location, organizational skills, ability to say no, ability to delegate, control over career path, personal and professional values, priorities, values, and emotional support outside of work, to name a few. Positively aligned, these drivers can pull a physician toward engagement. When they skew or turn negative, they can push them in the opposite direction toward burnout.

There are other personal drivers of burnout. Physicians are not taught the art of work-life balance during training. In fact, just the opposite: physicians are taught to ignore their physical, emotional, and spiritual needs. They are taught to work until they can't, and then to work more. The old joke, "The problem with being on call every other night is you miss half the good cases," wasn't really a joke. During the physicians' education they develop certain traits, qualities, and personas responsible for success. In an ironic twist, these same traits, qualities, and personas are the personal drivers for physician burnout. These include: perfectionist, workhorse, superman, check everything yourself, asking for help is a sign of weakness, and the patient comes first. Here's how they can go wrong:

1. Perfection is unobtainable, at least not by mere mortals. The small rise on the Y axis from excellence to perfection can utilize a great deal of time or energy on the X axis. Stated another way, a minimal gain that requires a large amount of effort is inefficiency. A physician can ill afford inefficiency in any part of their practice.
2. The workhorse and superman descriptions, like perfectionism, are not human attributes. Therefore, they, too, are not obtainable and should be replaced with better and more realistic human qualities.
3. "Check everything yourself" is not possible in today's medical office. What is possible is to set up systems and policies in your office that delegate responsibility to prevent omissions and mishaps.
4. Asking for help is a sign of strength, not weakness. It takes a healthy ego, good insight and maturity to realize that one needs help. Asking for help takes courage and is applaudable. We all need help at one time or another in our professional and personal lives.
5. "The patient comes first" dictum is problematic. If the physician has burnout or is sick in other ways, they may not be able to deliver quality care. Health care is a service industry so patient care and patient service are important, but self-care is at least equally if not more important, and should take precedence. If you have burnout or are infirmed or dead, you are not doing your patients any good.

Organizational Factors

Although individual physician factors are important drivers, the organizational factors seem to be the principal drivers for physician burnout. Organizational factors include productivity targets; method of compensation; the EHR; the organizational culture, mission and values;

scheduling and vacation policies; and the immediate supervisor. The leadership skills of the physician's immediate supervisor powerfully affect the physician's work satisfaction and stress levels. Hospitals, professional organizations, and companies like SVMIC have realized this even before the epidemic of physician burnout, and started leadership schools and leadership classes to mitigate its effects. But there is more to be done.

Physician burnout is at epidemic levels. As we have seen in part one, physician burnout can have dire consequences. If you have the symptoms or sequalae of physician burnout or know someone who does, please get help. Doing nothing is the worst thing to do. Your call to the TMF-PHP is confidential. We have resources that can help. Please contact the Physician's Health Program at 615-467-6411 or online at e-tmf.org.

The Federation of State Physician Health Programs provides a comprehensive listing of state programs here.

Turning a Negative into a Positive: Managing Patient Complaints

By Julie Loomis, RN, JD

Increasing concerns about the quality of healthcare have arisen as a result of the public perception that cost-cutting measures have caused premature discharge and clinical mismanagement of patients. Changes in healthcare coverage have generated concerns that medical care has become a profit-motivated business instead of a caring professional service. In response to these changes, medical offices should develop methods of dealing with patient complaints to positively impact patient satisfaction and potentially uncover hidden flaws in daily processes.

Every medical office should have a plan to address complaints by a patient or patient's family. At a minimum, medical offices should have in place mechanisms to inform patients of the complaint process; to receive and respond to complaints in a timely manner; to implement corrective action as necessary to resolve complaints; and to reassure the person filing the complaint that future care will not be compromised because of a registered complaint.

It's important that your patients know you're genuinely interested in patient feedback in order to improve the patient experience and respond appropriately to issues. One mechanism that can be used to inform patients of the complaint process is to include it in the practice's "new patient" brochure or on the practice's website. The brochure should be given to each new patient at their first appointment or mailed to the patient prior to their first appointment. Having response cards -is a method to garner potential complaint information from patients.

Upon receipt of any complaint, the staff should relay the complaint in a timely manner to the appropriate person. Complaints about medical care should go directly to the physician or provider involved; billing concerns should be referred to the account representative; and other concerns should be given to the administrator or designee.

Verbal complaints should receive a courteous response at the time they are presented. If possible, move the conversation to a private location. The person making the complaint should be given ample opportunity to discuss concerns without interruption. Do not argue or be tempted to place blame on the patient or the practice. Reassure the patient that you appreciate the opportunity to hear him/her out, you take concerns seriously and will promptly investigate the matter. Written complaints should be acknowledged and the response should include a message that the complaint will be treated as an opportunity to

collect more information and attempt to resolve the concern. After a thorough investigation, the findings should be communicated in an empathetic but concise manner. The complainant should be advised when corrective action has been taken. However, any corrective action that involves staff performance should not be communicated to patients or family members. Knowing that action has been taken on concerns brought to the attention of the practice improves the patient's perception of quality of care and confidence in the practice. Physicians and providers should be cautious to maintain confidentiality when the response is communicated to someone other than the patient.

All discussions with the complainant should be documented and retained in a file separate from the medical record. The patient or patient's family should be reassured throughout the complaint process that future care will not be compromised. In the rare situation when complaints become unreasonable or abusive, the physician retains the right to terminate the physician-patient relationship. SVMIC should be notified if the physician thinks the complaint may lead to a potential malpractice claim.

Be sure to document the entire process and use the following techniques, as appropriate, during the complaint process:

1. Treat the complaining patient with dignity, courtesy and due regard for privacy during the complaint-handling process.
2. Adopt a listening posture, i.e. making eye contact, sitting if possible, arms relaxed and not folded.
3. Allow the patient to state the problem completely, without interruption or argument.
4. Thank the patient for bringing the concern to your attention.
5. Accept the patient's feelings, and if appropriate, offer a statement of empathy such as "I understand your frustration" or "I'm sorry that your wait time today was longer than expected", without admitting fault or placing blame.
6. Obtain as much additional information as possible to facilitate investigation of the complaint and reassure the patient that attention will be given to the concern.
7. Provide information regarding steps which will be taken with an expected timetable.
8. Follow timetables promised whenever possible; if delays arise, inform the patient of the change.
9. Conduct a thorough investigation; interviews with physician or staff involved; and medical record review may be necessary.
10. Determine resolution of the matter and inform the patient accordingly.

Patient complaints are an opportunity to learn important information about the practice. Some complaints will be frivolous; but even frivolous complaints sometimes reveal more important issues that may be difficult for patients to articulate. Other complaints may point out a system weakness that if left unattended could lead to patient harm. If ignored, even minor complaints can become the foundation for a lawsuit. Prompt and thorough attention to complaints may mitigate the escalation of emotions and pay off for both the patient and the practice.

Tiering: Levels of Copayments

By Elizabeth Woodcock, MBA, FACMPE, CPC

Tiering is a concept that has moved from the pharmacy to the medical practice. For years, payers have tiered medications into categories. Certain medications cost the consumer more, while others are available at lower costs. This strategy has steered patients – and ordering physicians – to generic medications, which are available at a lower pricing tier.

The concept migrated to medical practices for office visits, with a higher copayment required to see some physicians. Some payers utilize tiers based on the type of physician, with primary care typically being available at a lower copayment. The place of service often triggers a higher copayment as well, with emergent departments being the highest. However, payers are also applying this strategy to physicians who are out of the network, and, in some cases, to those who are in network but considered higher cost and/or lower quality. Touts one payer: “in a tiered network, members pay less out-of-pocket for care from hospitals and primary care providers that are high-quality and lower cost.” Regardless of the application, tiering makes point-of-service collections a challenge, as financial responsibility can be significant. Furthermore, it’s not unusual for physicians to change tiers, which can leave the practice, as well as the patient, frustrated.

Because the allowance doesn’t change – the patient’s portion is what is altered – many physicians have no idea they’ve been tiered in the first place. Even if you did have knowledge of the tiering, it’s hard to determine how or why you got there. Of course, there is no “generic” physician so the demarcation used in the pharmacy field cannot be applied. The tiering criteria are not outlined in detail, and, argue many, are applied subjectively.

If you find yourself in a tier that creates a higher financial responsibility for your patients, it’s vital to reach out to the payer to understand the criteria for the tiers. Furthermore, provide knowledge to your employees about this situation – and how to handle patients who are confused by the patient financial responsibility. Finally, if this is all news to you, be aware that tiering may be coming your way soon.

Budget Act Extends GPCI Floor

By Elizabeth Woodcock, MBA, FACMPE, CPC

The Bipartisan Budget Act of 2018 featured an extension of the physician work geographic price cost index (GPCI) floor. As the work GPCI is a component of the Medicare payment formula, this declaration positively impacts physician reimbursement. On March 20, the Centers for Medicare & Medicaid Services (CMS) issued a memorandum instructing Medicare contractors to reprocess claims affected by the law.

The good news is that physicians in Alabama, Georgia, Kentucky, Mississippi, and Tennessee will see increases in Medicare reimbursement dating back to January 1, 2018 dates of service; the bad news is that more than 90 days' worth of claims have *already* been paid – and are candidates for reprocessing. Because the boost in reimbursement is so small – pennies, in some cases, this situation could prove to be a challenge.

The Medicare Administrative Contractors (MACs) are required to make the change, however, there is no guidance on the details of the so-called "automatic reprocessing." CMS' instructions include: "Contractors shall automatically reprocess…claims for localities and states impacted by the Work GPCI Floor fee increase for dates of service in calendar year 2018." While details aren't provided, a subsequent guidance by CMS is critical for physicians to review: "Contractors shall reprocess [the] claims [that] cannot be automatically reprocessed only if brought to your attention." This statement inherently gives latitude to Medicare contractors to *avoid* the payment boost – unless you raise the issue. If your Medicare business is small – or the financial impact minor – you may be relieved that the contactor can't "automatically reprocess" your claims. However, for physicians who a significant Medicare patient population, or those who perform surgeries, procedures, and other high-dollar services on Medicare patients, this instruction should set off alarm bells – and drive you to action.

Although CMS instructs the MACs to begin reprocessing claims as soon as possible, they are given six months to initiate the process. Therefore, if you haven't seen evidence of the additional monies owed to you (particularly if the "old" fee schedule continues to be perpetuated), take action by proactively bringing the issue to the contractor's attention, as CMS instructs.

Ultimately, this boost in payment – albeit small – is beneficial to physicians in the long-term. However, it could possibly be up to you to capture the advantage of the payment boost from the previous three months' worth of claims.

Editor's Note:

On April 5, the Palmetto GBA announced, *"Due to the retroactive effective dates of these provisions, your Medicare Administrative Contractor (MAC) will reprocess Medicare FFS claims impacted by this legislation. You do not need to take any action."* See full details here.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.