# (Crazy) Good Ideas for Employee Retention

**By Elizabeth Woodcock, MBA, FACMPE, CPC**

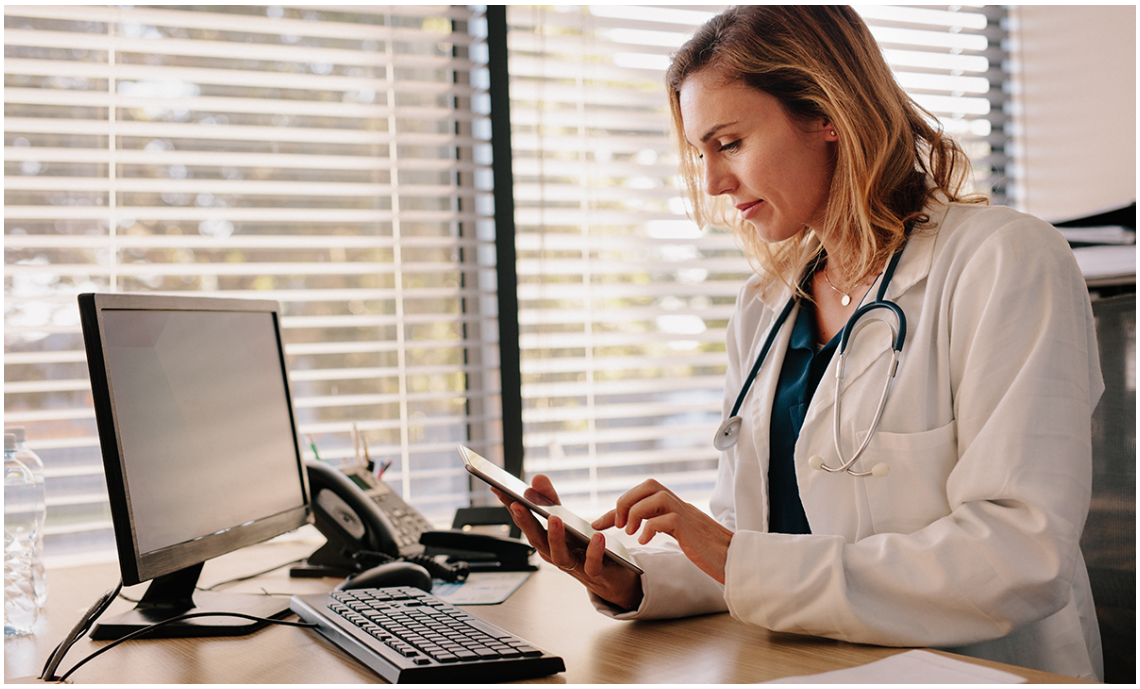
All bets are off for ideas to keep employees on staff. Consider the hotel chain in Germany that is paying for employee tattoos. Body ink may not be appropriate for your medical practice, but consider these 15 crazy good ideas that other practices have successfully deployed:

1. Host “Open Door” meetings – give all employees a chance to share their thoughts and ideas
2. Adopt a Family First initiative – allow flex work schedule or time off for family issues
3. Share patient and referring physician praise - consider hero award bonuses
4. Conduct a *colleague* satisfaction survey – ask employees to prioritize feedback and then take action to improve
5. Offer a retention bonus with pay-back clause
6. Keep employees who move (when possible) – regardless of their new location
7. Have employees develop a focused independent career plan - include short-term

and long-term career goals
8. Allow flexible schedules (including migrating from part-time to full-time – and back again) - work-from-home or hybrid opportunities
9. Orchestrate team bonding activities
10. Hold a “Staffle” (staff raffle) - give employees a chance to recognize fellow employees with additional entries into a monthly drawing
11. Give small, but impactful rewards or giveaways – a roving 'sunshine' cart with treats
12. Provide a welcome package for new hires and care packages for existing employees
13. Encourage virtual team games
14. Conduct a market wage assessment and adjustment, as appropriate
15. Partner with community colleges and training centers (for externships) - to provide continuing education

Whether it’s one of these off-the-wall ideas, or another that you or your team comes up with, thinking creatively to keep your employees engaged and motivated will undoubtedly help your practice attract, and retain, staff.

# Avoid Using Disclaimers for Dictation, Voice Recognition Software, Electronic Health Records



**By Jeffrey A. Woods, JD**

Providers are legally accountable for the accuracy of the information in their notes, and personal review of entries in a timely fashion provides the opportunity to make any needed corrections. All notes and medical record entries should be reviewed for accuracy and properly authenticated (signed) by the provider. Inaccurately transcribed dictation, errors generated by voice recognition software, or other inconsistencies within an EHR note, report, or other document may jeopardize patient safety. Entries prepared by transcription or software which lack evidence of review by the provider may serve as a “red flag” to attorneys who are examining the record for a potential malpractice suit. At the very least, this failure to review transcribed or electronic entries will certainly give the appearance of lazy, sloppy, or indifferent care.

Disclaimers should **not** be used as they will not lessen the provider's potential liability and will likely draw attention to the fact that the provider has not carefully reviewed his/her notes and is willing to accept any inaccuracies. Avoid using disclaimers such as: "Dictated but not read", "Signed but not read", or "Portions of the record may have been created with voice recognition software. Errors may have occurred...".

Turnaround time for entries to be posted in the record should not exceed 48 hours, although 24 hours is ideal. This includes time allotted for review/proofing prior to posting. Delays past 48 hours may cause problems with patients who should be followed closely. With such patients, providers should create written notes and keep them until the transcription is in the record.

Should you have any questions, please contact an SVMIC Claims Attorney or the Risk Education Department at SVMIC by email at ContactSVMIC@svmic.com or at 800.342.2239.

# Medicare Proposal for 2023 Reimbursement Released


**By Elizabeth Woodcock, MBA, FACMPE, CPC**

On July 7, the Centers for Medicare & Medicaid Services released the annual proposal for Medicare reimbursement for the coming year. In the absence of Congressional intervention, the payment rate for physicians will decline by 4.4% in 2023 based on the proposed conversion factor of $33.08, a decrease of $1.53 from the current factor of $34.61.

The recent ruling proposed other key changes to physician reimbursement in 2023, to include:

- **Broad application of office-based E/M rules**

  CMS is employing the American Medical Association's extensive revisions to all E/M codes, which include eliminating the use of history and exam to determine code levels for inpatient, observation, and "other" E/M services. See this link for the

AMA's changes to E/M codes effective January 1, 2023.

- **Extension of key public health emergency (PHE) relaxations**

  Under a separate decree, the PHE was extended until October 13. The proposed rule is paying for certain services for an additional 151 days (five months) following the conclusion of the PHE. This includes paying for telemedicine services with the "originating" site as the patient's home and permitting the services to be furnished in any geographic area. In addition, audio-only (telephone) visits will remain covered (with new CPT modifier - 93) and Federally Qualified Health Centers (FQHCs) will be able to continue offering telehealth services during this five-month period.

- **Expansion of non-physician services**

  Licensed professional counselors and other behavioral health practitioners can practice under general supervision, with additional payment allowances for clinical psychologists and social workers on care teams as core components of CMS' new behavioral health strategy. Additionally, Medicare beneficiaries are allowed to access audiologists directly for hearing aids and more with new CPT code, GAUDX.

- **Expansion of colon cancer screening**

  CMS is decreasing the age requirement for the study to 45 (from 50, for certain screening tests) and eliminating beneficiaries' cost-sharing on a follow-up colonoscopy to an at-home test.

- **Revisiting global periods**

  CMS questioned the use of global periods for surgeries nearly a decade ago and is again seeking feedback about the efficacy of global periods.

- **Initiating payment for chronic pain**

  The agency is expanding coverage to chronic pain management and treatment services with new CPT codes and accompanying reimbursement. The expanded coverage is proposed to extend to FQHCs and Rural Health Clinic.

The 2,066-page proposed rule is viewable at here. You can also review CMS' summary. Stay tuned for the final rule, which is normally issued the first week of November. Although the July 7 ruling is a proposal, it is often a blueprint for the coming year.

# A Reminder of the Value of a Jury of Your Peers

**By Alisa Wamble, JD**

When talking with physicians about the litigation process, a common concern is that a jury seated to hear their case will be comprised of individuals who do not and cannot understand the complexities of the practice of medicine. Many feel it is too risky to put their fate in the hands of individuals who are from all walks of life in terms of age, employment, background, socioeconomic status, life experiences, etc. In the case at hand, through very unusual circumstances, one of our insured gynecological surgeons, Dr. Baker[1], learned firsthand the value of having a jury of his peers hear the evidence in his medical malpractice case, weigh the credibility of the parties and the experts, and ultimately render a verdict in his favor.

The case involved surgical removal of a large cyst from Ms. Miller's abdomen to rule out cancer. Ms. Miller was a 65-year-old female who had hypertension, hyperlipidemia, gout, morbid obesity, rheumatoid arthritis, a history of an abdominal hysterectomy, and two C-sections. She was being evaluated for abdominal pain and constipation when she was

referred to Dr. Baker after a CT revealed a significant mass on the right side of her abdomen. After encountering extensive adhesions requiring adhesiolysis, Dr. Baker was able to remove the mass without any known complications. Dr. Baker stated in his op report that he retroperitoneally identified the ureters before removing the mass. Fortunately for Ms. Miller, the pathology revealed a benign condition, a serous cystadenoma. However, almost 18 months later, Ms. Miller went into renal failure. An ultrasound revealed the possibility of a chronic obstructive process of the left kidney, resulting in acute renal failure and necessitating dialysis. The plaintiff's theory in the lawsuit was that Dr. Baker had ligated the patient's ureter during the exploratory laparotomy (and bilateral salpingo-oophorectomy) he had performed a year and half earlier.

Filling in additional medical facts, Ms. Miller's BUN was 25, and her creatinine level was .82 immediately before Dr. Baker's surgery. On post op Day 1, her BUN was 26, and her creatinine was 1.25. She had good urine output and was afebrile. On post op Day 2, her BUN was 22, and her creatinine was 1.3. She had a mild post op ileus but was progressing appropriately and was discharged on post Day 3. The patient was to follow up with Dr. Baker six weeks post op, but she failed to do so. Six months after Dr. Baker's surgery, Ms. Miller saw her primary care physician for routine care. Labs ordered at that time showed that her BUN was 34, and her creatinine was 1.5. A year after those labs were drawn, Ms. Miller developed uremia and confusion, and an obstruction of the left ureter was ultimately diagnosed. The patient received hemodialysis and peritoneal dialysis. A nephrostomy tube was placed and subsequently removed. Ms. Miller never underwent a surgical reversal of the questionable left ureteral obstruction. Our experts surmised that she developed adhesions over the course of 18 months after Dr. Baker's surgery which ultimately caused an obstruction that led to the left kidney injury, in addition to the myriad of other health problems that likely also contributed to Ms. Miller's poor kidney function. The weak point in the case against Dr. Baker was that he and his office staff did not follow up with the patient after she failed to come in for her 6-week post op visit. An effort to call her, documented in the chart, and certainly a follow-up letter advising Ms. Miller that she needed to return for her 6-week post operative surgical checkup would have been invaluable in the defense of this case.

The lawsuit proceeded in a typical manner through the discovery process, which included disclosure of experts and depositions. However, the normal course of this litigation was drastically disrupted when the trial judge issued a surprising ruling wherein he found that Dr. Baker and his attorney had failed to comply with a local procedural court rule as the trial date approached. As a consequence, the judge determined that the case would not be tried by a jury and that he would conduct a bench trial instead. Over our strong objection, the bench trial proceeded. The judge heard all the evidence and rendered a written decision a couple of weeks after the trial. Inexplicably, the trial judge rendered a high six-figure verdict for Ms. Miller. The judge, acting as the single fact finder, stated in his ruling that he found parts of Dr. Baker's and his experts' testimony "unpersuasive" and "unreasonable." The judge concluded that Dr. Baker's actions fell below the applicable standard of care as enunciated by the plaintiff's experts and that he was negligent in his

treatment of Ms. Miller. Further, the judge opined that Ms. Miller suffered permanent injury to the function of her left kidney, pain and suffering, mental anguish, and diminished life expectancy, leading to a substantial verdict against Dr. Baker. We appealed the trial court's verdict on behalf of Dr. Baker, and the appellate court found that the trial judge had erred by taking away Dr. Baker's constitutional right to a jury trial and set the verdict aside.

Approximately two years later, the case was tried again with the same judge, the same experts, the same parties, and a local jury comprised of a mix of men and women, who ranged in age from 22 to 67, with occupations that included retail clerk, golf course maintenance worker, teacher, bank teller, nurse, sales professional, engineer, car salesman, and an unemployed individual. A defense verdict was rendered for Dr. Baker by this panel of fact finders after the case was tried before them for one week followed by two and a half hours of deliberation. After presenting proof that our physician defendant practiced good medicine, a very significant factor in the ultimate outcome of any healthcare liability trial is whether the fact finders think the defendant physician is caring and competent. If so, they find in favor of the physician most of the time. Interestingly, on the morning the jury deliberations were to begin, our defense attorney happened to see the juror who was a teacher arrive early with a blank flip chart of paper and markers. When the jury announced the verdict, she was the foreperson. We do not know what the jurors discussed or how they reached their decision, but this particular juror must have come to court that morning prepared to lead a discussion regarding different aspects of the proof and impressions of Dr. Baker as a physician and a person. It was rewarding when Dr. Baker finally had his day in Court before a full panel of fact finders and was fully vindicated. The plaintiff did not appeal the verdict, and our faith in our jury system was reinforced.

[1] The identities of parties involved have been altered.

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