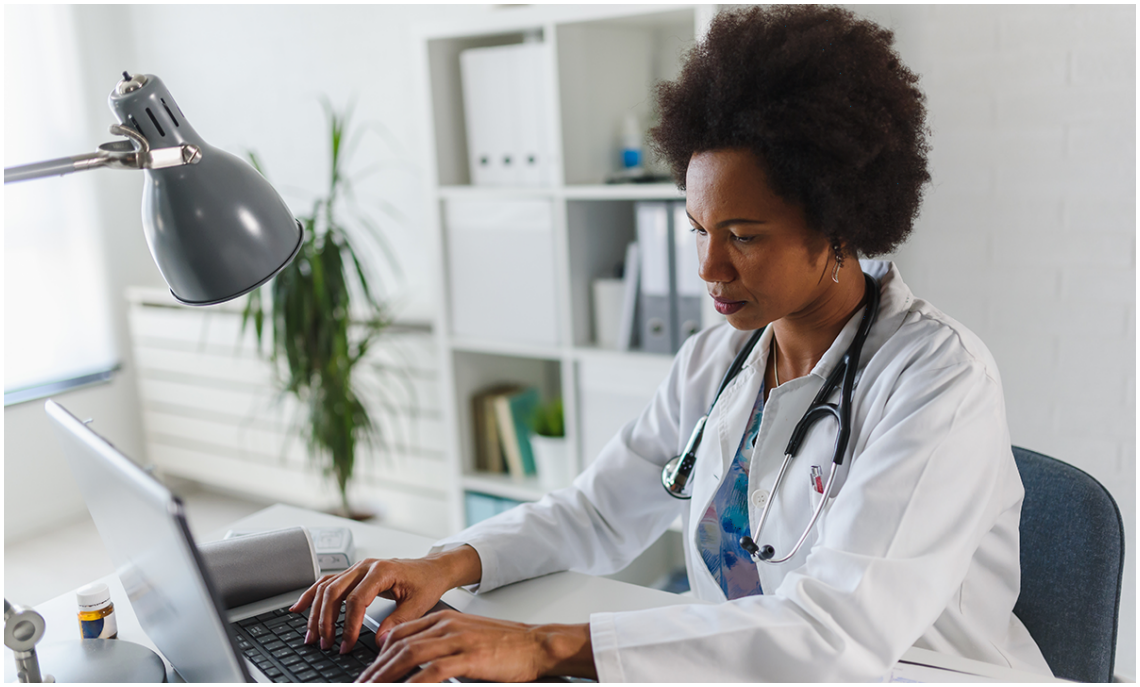
Medical Records: An Essential Element of the Defense



By Kathleen W. Smith, JD

Medical records are essential to the practice of medicine. Among several uses, medical records ensure continuity of care; facilitate effective communication among providers; serve as evidence of all pertinent facts related to the diagnosis and treatment of a patient; and serve as a basis for reimbursement. Medical records are also a critical component in the defense of a malpractice lawsuit. This closed claim shows just how important they are to a malpractice claim because this lawsuit probably never would have been filed but for the deficiencies in the record.

On September 6, 2015, new patient Jennifer Jones[1], who was then 35 years old, presented to an OB-GYN clinic for her well-woman exam. During the visit, she also reported that she recently found a lump in her right breast. Ms. Jones was seen by nurse practitioner Meredith Matthews. In addition to performing the well-woman examination, Ms. Matthews confirmed the breast lump first found by the patient. In her note for the visit, Ms. Matthews documented that the lump was a 2-3 cm mass, mobile and non-tender, in

the two o'clock position of the right breast. However, the note is completely silent as to what Ms. Matthews planned to do next. Approximately one year later, Ms. Jones, who had since moved to another state, was diagnosed with breast cancer. She underwent chemotherapy, bilateral mastectomy, and radiation. What happened during the interim between Ms. Jones' appointment with Ms. Matthews and her cancer diagnosis? This, as it turned out, became the basis for Ms. Jones' lawsuit against Ms. Matthews, her supervising physician, and her employer, the OB-GYN practice.

Ms. Jones claimed that Ms. Matthews dismissed her concerns about the breast lump during the visit, telling her that it was "just" a fibroadenoma and "not to worry about it." Ms. Jones alleged that Ms. Matthews breached the standard of care by failing to further investigate the mass, thus causing a delay in the diagnosis and treatment of breast cancer. She also claimed that Ms. Matthews "refused" to order a mammogram.

Ms. Matthews maintained that, while she advised Ms. Jones that the mass was likely only a fibroadenoma, she still recommended ordering a breast ultrasound to further investigate the mass. Then, if indicated by the results of the breast ultrasound, a mammogram would be ordered. Unfortunately, the visit note is completely silent as to this plan. Ms. Matthews believed that she was called away to assist another patient, and she just did not return to complete the dictation. The dictation ends mid-sentence, which is consistent with her explanation of being called quickly away.

Although the visit note does not document the treatment plan for the mass, other records corroborate the plan. There are numerous phone notes and messages documenting communications between the clinic staff and Ms. Jones discussing breast ultrasound vs. mammogram and Ms. Matthews' recommendation for ultrasound first, then mammogram if indicated. During discovery in the lawsuit, the phone records for both the clinic's phone and Ms. Jones' phone were obtained, and those phone records were consistent with the phone notes and messages documented in the chart. This supplemental supporting evidence was essential to the defense of the case, since it directly refuted Ms. Jones' primary claim that Ms. Matthews dismissed the significance of the breast mass and did nothing to follow up on it.

Additional corroboration was the fact that the OB-GYN clinic scheduled Ms. Jones for the breast ultrasound at the local breast imaging center. Ms. Jones did not keep the ultrasound appointment, and she never returned or followed up with the clinic. After making the ultrasound appointment, the clinic never followed up with her either.

There are several important points to learn from this case.

- Do establish a workable, reliable internal process for those times when you are unable to complete your documentation in one sitting. Determine what is workable and reliable for you and your practice. It could be anything from utilizing an internal workflow in your EHR system to writing a sticky note and putting it on your desk or computer. Plan ahead for how you will return to the work after being interrupted, because the interruptions will certainly occur. Additionally, encounters cannot be

billed until the note is completed.

- Do not simply sign off on the note. Doing so may be the reason you are included in the lawsuit. Although it was not discussed above, Ms. Matthews' supervising physician signed off on the note for Ms. Jones' visit. If you are a physician supervising an advanced practice provider, do pay attention to the note that you are asked to review. Check it like you would check your own work. If something is missing from the note that you would expect to see there, follow up with the provider.
- Do establish a workable, reliable internal process for following up with patients for whom you have ordered outside testing and follow-up appointments. What is important is that it is workable and reliable for you and your practice. The process should enable you to see who has not had the outside testing you ordered and who has not returned to the clinic in follow-up. If you need some ideas for implementing this type of process in your office, see "Tracking Procedures" for a helpful informational resource discussing this topic.
- Although this point was also not discussed earlier in the article, Ms. Jones and/or her attorney requested a copy of the clinic's chart prior to filing the lawsuit. The clinic provided most of the chart but not the phone notes. After the lawsuit was filed, the complete record was produced. When a practice is asked for a copy of a patient's record, do read the request carefully and provide copies of all documents requested. Commonly, a request for medical records asks for "each and every" document contained therein. Sometimes, providers interpret their "record" to mean only visit notes that they have created, not copies of phone notes, correspondence, or records received from outside providers. As this closed claim shows, this is a mistake that can re-surface during a lawsuit. If you ever have a question about whether or how to respond to a request for medical records, contact SVMIC and one of the attorneys in the Claims Department will be glad to assist you. We can be reached at ContactSVMIC@svmic.com or 800.342.2239.
- Finally, do take the time to document phone and other communications with patients, and make sure that your staff does the same. Although these interactions may not seem as important as the visit itself, all patient communication is important and should be documented. Without the phone notes here, this lawsuit probably would have had a much different ending.

How did this case end? After some time and discovery, Ms. Jones dismissed her lawsuit. By the time of the lawsuit, Ms. Jones was in remission from her breast cancer, and her health was otherwise stable. Her move to a new state probably made pursuing the lawsuit more difficult that she originally anticipated. Further, her lawyer likely explained just how damaging the phone notes and corroborating phone records were to her case. That evidence made it very unlikely that a jury would believe her version of events over Ms. Matthews' explanation of what happened.

[1] Names and dates have been altered.

Risk Matters: Telemedicine

By Jeffrey A. Woods, JD

Governmental shelter-in-place orders and the need to avoid unnecessary physical contact driven by the coronavirus pandemic have caused many providers and patients to suddenly turn to the virtual world to provide and receive care. While this has generally been good for the healthcare system and patient safety, telemedicine is not an appropriate modality for all clinical presentations. Some medical issues cannot be resolved over the phone, or even with video, and require an in-person visit. The physician must have enough information to form an opinion about treating the patient; optimally, the provider will either have relevant medical records or be able to obtain information during the telemedicine encounter. If not, or if the medical issue is one that cannot be resolved via telemedicine, the physician should refer the patient for an in-person encounter and advise them of the next steps. Delivering healthcare through telemedicine requires the same compliance with the standard of care, as well as applicable laws and regulations, as in the treatment of patients in the traditional setting.

The Evolution of ‘Incident to’ Billing

By Elizabeth Woodcock, MBA, FACMPE, CPC

‘Incident to’ billing has been a challenging topic since its creation by Medicare. The rules – which allow advanced practice providers to be reimbursed at the full physician rate by Medicare when seeing patients in an office and directly supervised by a physician – are complex and, arguably, subject to interpretation. There have been a bevy of practices found in non-compliance with the rules, which has resulted in expensive paybacks.

Perhaps not surprising, the Medicare Payment Advisory Commission (MedPAC) issued their recommendation to eliminate the provision. The issue, states MedPAC, is that ‘incident to’ is not only costly for the Medicare program, but it “obscure[s] policymakers’ knowledge of who provides care to Medicare beneficiaries.” That’s an accurate statement, as the APP is essentially hidden behind the billing physician on the claim.

Although Medicare did not move forward with the 2019 recommendation, there are signs that other insurers are. United Healthcare, for example, announced a new policy titled: “Advanced Practice Health Care Provider Policy, Professional,” with an effective date of March 1, 2021: “The policy is being updated to require that an Advanced Practice Health

Care Professional must report services rendered within the scope of their licensure or certification using their own NPI number."

For some practices, this policy change won't matter as they have already transferred their APPs to independent status. This indeed is the trend, as practices have assessed the cost/benefit of this manner of billing. At issue is the loss of 15% of revenue, as an independent APP is paid by most insurers at 85% of the fee schedule. However, the benefit is that the office does not have to constantly manage the requirement for "direct supervision" – and perhaps even trickier, the necessity of engaging the physician when the plan of care changes.

The Medicare Benefit Policy Manual states:

> *"…[T]here must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment."*

This latter requirement is particularly challenging from a practice management perspective: Who should the APP notify when the course of treatment is changed? Who is going to communicate with the physician that the patient needs to be seen? How do we handle the patient while he/she waits? What is the impact on the physician's schedule when he/she is called to assist the APP with a course of treatment change? If the physician is not called, what do we say when the patient calls after receiving a bill with the physician's name on it? - These questions relate to a Medicare patient, but the issue gets further complicated when considering that each insurer has its own rules about the so-called 'incident to' billing. Many, for example, require an "SA" modifier to be attached to the CPT code to demarcate that an APP was the rendering provider. The burden on the practice – and the patient – has become so high that some practices have eliminated 'incident to' billing altogether.

Migrating away from 'incident to' billing was nearly impossible in the past. In fact, many practices were forced to treat APPs under these rules because insurers would not recognize and enroll them as independent providers. That is changing.

Importantly, this issue of billing is separate and distinct from the treatment of APPs from the perspective of scope of practice – which is a state issue – and of supervision in accordance with your practice's policies and procedures. In fact, billing 'incident to' simply adds another layer of rules on top of an already complicated issue. It may be an opportune time to consider how your practice is addressing the issue; please contact our Medical Practice Services department at ContactSVMIC@svmic.com or 800.342.2239 for assistance.

For more information about Medicare's rules for 'incident to' billing:

MLN Matters SE0441

Medicare Benefit Policy Manual, Chapter 15, Section 60

MedPAC recommendation (Pages 158-162)

United Healthcare’s New Policy

2021 Changes to RVUs: Ripple Effects

By Elizabeth Woodcock, MBA, FACMPE, CPC

By now, physicians have transitioned into the new rules to code evaluation and management (E/M) encounters in the office.*[1] What may not be recognized, however, is the changes to the relative value units associated with the codes. In addition to the shift in coding guidance, the American Medical Association and the Centers for Medicare & Medicaid Services combined forces to implement a new valuation methodology for the relative value units associated with the remaining nine office-based E/M codes -- 99202 through 99205, 99211, and 99215. While this calculation doesn't impact the way you practice, it has two important effects: (1) it boosts your reimbursement for these codes; and (2) it alters your reporting of productivity.

The change in reimbursement is substantial. A visit coded as a 99215, for example, will pay 23% more than it did just weeks ago (that is, prior to January 1, 2021). Table One displays the change in rates for Medicare for physicians in Tennessee (MAC 1031235) between 2020 and 2021, accompanied by the corresponding shift in total relative value units. Other states can view the changes here. While this is great news for Medicare reimbursement, the glad tidings don't end there. Indeed, as most commercial payers use

the Medicare Resource-based Relative Value Scale's relative value units to pay physicians, these increases will reverberate across your practice's entire book of business.

Table One. 2020-2021 Changes to Office E/M Codes

		2020		2021		2020-2021 Change (%)	
CPT Code	**Short Description**	**Allowable**	***Total RVU***	**Allowable**	***Total RVU***	**Allowable**	**Total RVU**
99211	Office o/p est minimal prob	$21.57	0.65	$21.08	0.66	-2%	2%
99212	Office o/p est sf 10-19 min	$42.52	1.28	$52.67	1.63	24%	27%
99213	Office o/p est low 20-29 min	$70.79	2.11	$85.98	2.65	21%	26%
99214	Office o/p est mod 30-39 min	$103.10	3.06	$122.31	3.76	19%	23%
99215	Office o/p est hi 40-54 min	$138.79	4.11	$171.03	5.25	23%	28%
99202	Office o/p new sf 15-29 min	$71.47	2.14	$68.23	2.12	-5%	-1%
99203	Office o/p new low 30-44 min	$101.55	3.03	$105.40	3.26	4%	8%
99204	Office o/p new mod 45-59 min	$155.84	4.63	$158.17	4.87	1%	5%
99205	Office o/p new hi 60-74 min	$197.24	5.85	$208.99	6.43	6%	10%

Internal productivity reports may look peculiar, particularly compared to historical records. Physicians who rely heavily on office-based E/M encounters will appear to be 5, 10, maybe even 25% more 'productive' on reports. Of course, this result will occur only when your practice management system loads the 2021 relative value units. For some practices, this may have little impact other than the numbers looking higher, but for others, there is an important consideration to be made. For practices that rely on relative value units to dole out bonuses -- or divide income among physicians -- the change in units will have a significant effect. Indeed, your practice may want to discuss how to handle this now, rather than waiting until cries of inequity are raised. Consider a dermatology practice with dermatologists, MOHS surgeons, and dermatopathologists; the first specialty will see a sizable spike in units, while the other two will not. With regard to the compensation plan, will there be a conversion back to the 2020 units? Is a transition year in order -- or maybe two? Myriad questions may arise; and there are no right answers. In fact, my mantra for physician compensation plans is that all physicians feel equally treated unfairly. However,

it's important to consider avoiding the worst outcome, which is being caught by surprise, by reviewing and discussing the situation now.

Use this handy (and free) tool to look up relative value units and Medicare reimbursement for any code, year, and location: Search the Physician Fee Schedule | CMS

SVMIC also has prepared a convenient presentation on E/M Coding Changes which you can view at your convenience here.

[1] Please review the AMA education about the new guidelines, which started on January 1, 2021.
