# The Long Road of Litigation

**By Alisa Wamble, JD**

This Tennessee case involved the alleged wrongful death of a 42-year-old male who presented to the ER in early 2008 complaining of lower abdominal pain, fever, nausea, diarrhea, anxiety and severe distress. The patient had a four- to five-year history of diverticulitis, which was managed by diet. Dr. Long[1] was the ER physician who examined the patient and ordered an x-ray and labs. A CT was also ordered and initially read as showing no free air in the abdomen. Dr. Long treated the patient with IV antibiotics and fluids. He diagnosed acute diverticulitis with localized peritonitis and decided to have the patient admitted. The on-call hospitalist was not available so Dr. Long contacted Dr. Ellis - who was out of town and not on call that night. Dr. Ellis agreed to have the patient admitted in the late night/early morning hours and planned to consult a surgeon the next morning. Early the following morning, the patient was found unresponsive in asystole and could not be revived. The autopsy noted disease of the rectosigmoid colon with perforation, abscess formation, obstruction, peritonitis, remote subendocardial infarction with probable superimposed acute ischemic changes suggestive of possible arrhythmia. The CT from the prior evening was overread after the patient's demise, and it noted a finding of free air. The patient was married and had three children who were 16, 12, and 5 at the time of his death. His life expectancy was likely another 35 years, and his annual income exceeded $150,000. It was a tragic, unexpected death less than 12 hours after presenting to the emergency room.

In late 2008, a suit was filed by the patient's wife against Dr. Long and the hospital. The plaintiff alleged that Dr. Long failed to order an emergency surgical consult, failed to keep the patient in the ER or transfer him to the ICU, delayed ordering the CT and failed to follow ER policies and procedures. The plaintiff's theory was that the patient had a perforation in his rectosigmoid colon that could have been repaired by emergency surgery.

We had multiple supportive experts who felt that Dr. Long's care was entirely defensible. They believed there was no indication of a medical emergency or the need for an immediate surgical consult. Even if the surgeon had been called, he likely would have administered an antibiotic to calm the infection before considering surgery the following day. Our experts thought the patient died from an unexpected and acute cardiac event that was aggravated by diverticulitis. They also agreed with the radiology interpretation that there was no free air in the retroperitoneal cavity and there were clear indications of diverticulitis.

The depositions of the treating physicians were helpful in the defense of the case. They confirmed there was no fluid, free air or inflammatory process in the peritoneal cavity.

There was no evidence of a bowel perforation at the time the patient was treated in the ER or when the CT was performed. Even if an emergent surgical consult had been ordered, they did not think the outcome would have changed.

Dr. Long and our defense counsel believed the case was defensible and should be tried. After multiple continuances by the Court due to scheduling conflicts, the case was tried in 2011. The plaintiff's attorney voluntarily dismissed the case on the second day of trial because his proof was not going as well as he had expected. Some states allow a case to be dismissed by the plaintiff any time before it is submitted to the jury, and the plaintiff has the option to re-file the case once more within a year. This plaintiff did just that and re-filed the case in 2012.

The plaintiff's settlement demand exceeded $5,000,000 (primarily based on the loss of the patient's income and the loss of consortium claims for the wife and three children). Dr. Long, defense counsel and SVMIC desired to continue to defend the case. While the case was pending the second time, we developed additional expert support (and ultimately had two ER doctors, a general surgeon, and a radiologist) along with supportive testimony from the patient's gastroenterologist and the pathologist who performed the autopsy. The plaintiff also further developed expert testimony that the cause of death was septic shock and hemodynamic compromise.

The hospital grew weary and settled with the plaintiff before the case was tried for the second time in 2014. Dr. Long went to trial and received a unanimous defense verdict. Afterwards the plaintiff filed a motion for a new trial, and it was granted by the Court. The trial judge set the defense verdict aside because she thought the jury might have been confused as to whether the defense was claiming that the patient contributed to his demise. (The patient's primary care physician had testified in his deposition that he had referred the patient to a surgeon to address his chronic diverticulitis, but the patient did not go.) The judge's ruling was extremely disappointing because the defense did not allege that the patient contributed to his death during the trial.

The case was set for trial again (before a different judge) and was ultimately tried for a third time early last year. Fortunately, Dr. Long received another unanimous defense verdict. The plaintiff did not file any post trial motions challenging the verdict or an appeal, and the case was finally dismissed in mid-2017. This was a stressful situation for all involved, and the case weighed heavily on both parties for nine years. Dr. Long maintained, and SVMIC supported, his steadfast desire to defend his care. Even though the litigation process is painfully slow and fraught with worry and expense, good medicine deserves to be defended. The tortuous course of this litigation tested Dr. Long's commitment to standing up for his care, but his patience and perseverance ultimately prevailed.

When our doctors are sued, we find they often feel isolated and discouraged – especially when the litigation process seems unfair. It is an uncomfortable feeling not being in control and in unfamiliar territory. Just remember that you are not alone on this journey. SVMIC and your defense counsel will provide you with the best possible resources and support

throughout the course of your lawsuit. We will be with you to its conclusion even when the road is long and difficult to travel.

[1] All names have been changed

# Should You Use a Chaperone?

**By Stephen A. Dickens, JD, FACMPE**

Given the recent flood of high-profile sexual misconduct claims in the news, SVMIC has received an increased number of questions surrounding the topic of chaperones in an exam room. While there are no legal requirements to do so, the goal should be to make the patient feel comfortable while also protecting the physician against accusations resulting from a misunderstanding. With the increased media focus and sensitivity on the subject, now is a good time to review your office policies and procedures.

SVMIC's best practice recommendation is to offer a chaperone during any procedure that requires the patient to disrobe. Sensitive examinations such as breast, pelvic, genital and rectal exams should always be chaperoned, regardless of the patient or physician's gender. The presence of the chaperone should be documented. If the patient declines a chaperone, the discussion and refusal should likewise be documented. Any request for a chaperone should be honored, regardless of the nature of the examination.

If a medical student or other non-practice personnel are accompanying the practitioner during office visits, explain this to each patient prior to bringing the student (or other personnel) into the examination room so that you may obtain his/her consent first. It is prudent to document the patient's consent, or refusal, in the medical record. Practice staff should serve as a chaperone while students should not fill the role.

**The American Medical Association Code of Medical Ethics Opinion 1.2.4 offers the following guidance:**

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

**Physicians should:**

(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.

(b) Always honor a patient's request to have a chaperone.

(c) Have an authorized member of the health care team serve as a chaperone. Physicians

should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.

(d) In general, use a chaperone even when a patient's trusted companion is present.

(e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

Taking steps to help a patient feel comfortable during a physical examination is helpful in building a solid and trusting relationship. Providing the patient with information about the various types of examinations and the details of what to expect can serve to alleviate anxiety and help prevent a misunderstanding as to the appropriateness of certain actions during the examination.

# Physician Burnout: Recognize the Signs

**By Michael Baron, MD, MPH, FASAM**

Some physicians are familiar with the Tennessee Medical Foundation - Physician Health Program (TMF-PHP) - many more are not. Unfortunately, this can have dire consequences. The TMF-PHP's mission is to help the 15-20% of physicians impaired by mental and behavioral illnesses, which includes mood disorders, boundary violations, disruptive behavior, substance use disorders and burnout. This article, and three more that will follow in 2018, will focus on Physician Burnout - the causes, clinical presentations, impairments, treatments and outcomes. Physician burnout is a pervasive problem that can impair clinical competence, shorten careers, distress families and is an independent predictor of reporting a major medical error and being involved in a medical malpractice suit. SVMIC wants to educate its policyholders about burnout to prevent tragedies like the one described below.

During the steamy month of August, I met the grieving widow of Dr. W[1], who died in July from a self-inflicted shotgun blast to the chest while the family was at church. Dr. W's death was tragic, and Mrs . W. asked that his death be used as a clinical illustration so no other family, office or population of patients goes through this grief. As I sat with her and listened to her visceral grief, I recalled the articles I had reviewed about physician burnout. Years in residency training taught me to reflexively review the differential diagnosis as the signs, symptoms and demographics become known. The diagnosis became evident long before she was through describing what happened. While she talked, I recalled that doctors practicing in the trenches of primary care are at much higher risk for burnout than doctors in other specialties, as are mid-career physicians versus those in early or late careers. Dr. W. had numerous risk factors for burnout, which he developed long before he became severely depressed.

Dr. W. grew up in a small Tennessee town and met his wife while in the military. He traded years of military service for a medical education and was happy during his military obligation. After being honorably discharged, he was recruited by the hospital to a rural west Tennessee town. After fifteen years in practice, many of which were without a vacation day, he had signs of burnout. He avoided family and social activities such as church, ball games, shopping and the gym. Like many doctors, he didn't know how to say no, so he avoided having to do so. Dr. W. became frustrated, emotionally depleted and less empathic - he didn't have any more to give. He resented his patients and his office. He told his wife about 3 years ago he felt like "a robot going through the motions."

Approximately 1 year before he completed suicide, two significant events occurred. Dr . W's trusted front office clerk of 8 years, "Linda", was caught embezzling money.

Apparently, Linda was stealing from the practice almost since the day she was first employed. Dr. W. hired her and trusted her; she would even babysit for his children on that rare occasion when he and his wife would go out. Mrs. W. had to call the police to have Linda arrested because Dr. W "couldn't face that conflict." The court entered a restitution order that Linda was not able to honor, creating additional conflict. The second event occurred when a for-profit private corporation purchased the county hospital and offered to buy his practice. "Freedom" he told his wife, "no more financial, office, billing or credentialing worries. And no more Linda issues." With little legal or business advice, Dr. W. quickly sold his practice. Within 4 months, he regretted it.

The new practice management group implemented changes including a time clock, 45-minute new-patient appointments, 12-minute follow-up appointments, a new electronic health record (EHR), rigid payment structures and financial targets.

Mrs. W had read about burnout in one of her husband's journals and said, "For at least 3 years he fit all the symptoms." He became depressed his last year of life. He was afraid to reach out. He took samples of antidepressant medications. He told his wife if he were treated for depression by a psychiatrist, the licensing board would investigate. "I'll lose my license; it'll just make it worse." He became more despondent and chose the permanent resolve of suicide as his way out.

Although Dr. W had never mentioned the TMF-PHP, the hospital's new CEO referred Mrs. W to us soon after the funeral. At our first meeting at a coffee shop in Jackson, I explained our full mission, and she began to sob uncontrollably. She realized that the TMF-PHP might have been able to help her husband and prevent his death, and she asked that I use her husband's story to help prevent it from being repeated.

A physician's completed suicide impacts the village. The family loses a loved one and wage earner, the community loses a valued member and employer, and patients lose their doctor. At his wife's request and with her help, Dr. W's emotional state was examined. A root cause analysis of his professional life revealed many issues on multiple levels that are relevant to physician health.

Like most health care providers, Dr. W was co-dependent. He put the health and welfare of his patients before his own. Even when he was sick with a febrile illness, he was at the office taking care of patients who were less sick than he was. He had difficulty saying no. Co-dependence may feel like a bonanza for patients; it is certainly venom for a physician. Co-dependence can cause over-prescribing, over-working, a feeling of being used, quality of care problems, and can be a precipitator of burnout.

Burnout is currently an in vogue word that, because of its impact and severity, is being discussed at all levels of organized medicine. The National Academy of Medicine, American Medical Association, Federation of State Medical Boards and Federation of Physician Health Programs are all collaborating with many other national and state medical groups to discuss physician burnout.

Burnout is devastating to the physician's wellbeing in the three realms of their life - work, social and home. The classic signs of burnout include emotional exhaustion, loss of the passion to practice medicine and being too drained to work effectively. Burnout includes depersonalization, loss of empathy, lack of efficacy and purpose and loss of a desire to help a patient. The prevalence of physician burnout is staggering;  over 50% of practicing physicians have at least one burnout symptom. Dr. W. was very isolated and had little "community." He worked long hours with little time off and less time away. The practice management group that was to provide "freedom" removed what little control he had, further exacerbating his burnout. His burnout persisted for years before it was eventually supplanted by depression.

Depression and burnout are not the same but have related antecedents. Dr. W inappropriately and ineffectively treated himself for depression, something no physician should ever do. He was worried if he reached out for help, his medical license would be in jeopardy. The TMF-PHP has no reporting mandate in an effort to provide protection and confidentiality to physicians who reach out for help.

The following three articles in this series will discuss physician burnout, treatment and prevention in more detail. Please reach out if you need help, Mrs. W wishes her husband had.

See the Tennessee Medical Foundation's website for more information.

[1] All names have been changed for confidentiality

# Developing Protocols with Advanced Practice Providers

**By Julie Loomis, RN, JD**

Developing protocols with a nurse practitioner or physician assistant will require time and attention to detail, but it is one of the most important steps toward an effective, collegial and protective physician-PA/APRN relationship. Protocols are not “cookbook” recipes for managing clinical conditions, but are a method of ensuring an advanced practice provider (PA/APRN) is practicing at his/her highest level of competency and training within generally accepted specialty guidelines and legal authority. The protocol is generally an agreement between the PA/APRN and the physician for the purpose of defining the scope of prescriptive authority and other medical acts to be exercised by the PA/APRN in compliance with state law and the administrative rules and regulations promulgated by their respective licensing boards. Protocols allow them to utilize their assessment and health care management skills with a high degree of independence and in accordance with established standards. The effectiveness of the health care team is enhanced by empowering advanced practice providers to apply their knowledge and skills through the use of treatment protocols.

Most states allow nurse practitioners and physician assistants to perform certain functions such as diagnosing, treating and/or prescribing medications under protocols developed jointly with a licensed physician. Physicians must enter into a treatment protocol or collaborative practice agreement (CPA) with the PA/APRN[1] Protocols are specific to the patient population and broadly the standard of care. Protocols must also include a method of consultation and referral, prescriptive privileges and medication formulary, plans for coverage of the healthcare needs of a patient in the emergency absence of the PA/APRN, and any required chart review or co-signature by the physician. Finally, collaborative practice agreements and protocols should be signed by both the physician and PA/APRN.

Often, each state’s protocol requirements are extensive and lengthy. Several state licensure boards including Alabama, Arkansas, Georgia, Kentucky, Mississippi and Virginia provide online sample protocols, collaborative practice agreements and templates or forms for prescriptive authority that may be used to comply with state. It’s important to consult the respective licensure board of each party to the agreement. Often, the medical board will have more regulations for collaboration with or supervision of advanced practice providers than the nursing board. However, in states without specific sample forms, templates or guidelines, the protocols should be specific to the patient population, define the scope of authority delegated to the PA/APRN and broadly outline the standard of care. Some states offer lists of medical guidelines that may be utilized. Check with your

licensure board for specifics, but the minimum elements of a protocol agreement include:

**Reference Guidelines for Practice**

Protocols are not intended to provide a course of treatment for every condition in every patient. They are context dependent, giving the PA/APRN a range of condition specific protocols typically encompassing the services routinely provided in the course and scope of medical practice, as well as any additional procedures for which the PA/APRN has obtained specialized training and credentials. Simply adopting a text or other medical publication is generally not sufficient to meet state medical board standards. Examples of reference guidelines include the State Nurse Practice Act, journal articles, textbooks, approved procedure manuals, approved clinical research protocols, agency policies and procedures, online protocols such as *Up to Date* drug and laboratory references and other recognized medical standards of care.

**Physician and Backup Physician Availability**

There must be physician or backup physician availability at all times. The protocols/CPA should include a method of consultation with contact information.

**Licensure and Similar Specialty**

All states within the SVMIC service area require both the physician and PA/APRN to maintain a current, unencumbered license to practice in the state (typically retired physicians are ineligible). The supervising or collaborating physician must have experience and/or expertise in the same area of medicine as the PA/APRN. The APRN may have a limited scope of practice based on his or her education, training and national certification.

**Prescriptive Privileges**

A protocol must be in place if a PA/APRN has been delegated prescriptive authority. Protocols should include a medication formulary of drugs and medical devices that are approved to be prescribed and/or issued by an authorized prescriber, which may include controlled substances.

**Situations Requiring Consultation With the Physician**

This section indicate when onsite evaluation or telephone consultation is required. Typically, situations that are not within the PA/APRN's scope of practice: situations posing an immediate threat to the patient's life; when a patient is referred for emergency management; conditions that fail to respond to the management plan within an appropriate time frame; findings that are unusual or unexplained; or whenever a patient requests physician consultation and in the event of an unexpected outcome.

**Documentation**

The method of documentation, physician review and signature (if required) should be indicated. Generally, this will be defined in the board rules.[2]

**Review and Signature**

Written protocols should be jointly developed, dated and signed by both the physician and PA/APRN.

**Maintained at each practice location**

Protocols/ and medication formulary must be available for inspection at all practice locations. You may develop a protocol that covers multiple practice locations and multiple relationships, but each supervisory/collaborative relationship must be captured individually by completing the forms in the licensure board.

Additionally, protocols may also cover the PA/APRN's authority to delegate duties to other licensed or unlicensed personnel, how to handle patient requests to see a physician, a quality assurance plan if required (Mississippi) and other mutually agreed upon practice guidelines. Both the Tennessee and Georgia medical boards offer *Frequently Asked Questions* regarding supervision to include information on protocols which is a helpful "at a glance" tool.

Remember to update the protocols according to the board's guidelines  at least every other year (annually in Arkansas and Georgia), when there is a change in the relationship, or when new procedures are authorized after completion of advanced medical training. Keep in mind, the physician should always have experience or expertise similar that of the PA/APRN before signing off on procedures to be performed by them. Notice of any change or termination of a protocol or collaborative agreement must be given to the applicable boards within a defined time period which is found on the state board website.

Please see our page listing state-specific regulations. For questions or links to additional resources, please contact SVMIC.

[1] In Kentucky- APRNs are allowed to practice independently without a collaborative agreement. However, they must enter into a collaborative agreement with a physician in order to prescribe medications.

[2] See this resource on our website for more information on APP signatures in the EHR

# The QPP Portal is Open: Submit Your 2017 Data

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

The Centers for Medicare & Medicaid Services (CMS) opened the reporting portal for the Quality Payment Program (QPP) on January 2. The deadline to submit your 2017 performance data is March 31, 2018. The portal provides one-stop shopping, allowing users to enter performance scores for all three categories of the Merit-based Incentive Payment System (MIPS).

The new portal offers several benefits. In addition to being comprehensive, CMS reveals real-time scoring, as well as the ability to "pause" and return to the portal to update data at any time. There is no "save" button to press; the portal automatically retains all information. Users can submit data as often as they'd like. Finally, participants can manually upload a file generated from their electronic health record (EHR) system, a particularly appealing option for those practices that are concerned about the inability of their EHR vendor to accomplish the task of submitting the data on their behalf.

You must have an Enterprise Identity Management (EIDM) account and credentials to sign-in and submit data; this is the same account that you have used for previous reporting programs such as the Physician Quality Reporting System. The portal allows submission for a practice as a group – or for each individual eligible clinician within a practice.

The link to the portal can be found here.

# Distractions in the Workplace

**By Julie Loomis, RN, JD**

Distractions and interruptions are a fact of life in today's healthcare environment, but that doesn't mean a practice should simply accept them and the threat they pose to patient safety. Identifying the sources and frequency of distractions and interruptions allows for implementation of strategies to avoid or minimize at least some of them. Reviewing the use of personal electronic devices is an area of "low hanging fruit" where relatively straightforward, low-cost behavior modifications can make a significant difference.

While no one disputes that new technologies may bring a host of advantages to the clinical setting, adding them to an already chaotic healthcare environment can also interrupt workflow and distract from good patient care. As public awareness of this risk has grown, reports of near misses and medical errors resulting from the use of technology have increased. We now see advertisements encouraging anyone who believes they suffered a medical injury resulting from distraction to contact an experienced malpractice attorney, and plaintiffs' attorneys use the discovery process during litigation to request the cell phone records of physicians which may be used as evidence. Several healthcare organizations have developed guidelines on the use of new technologies and a number of professional organizations, such as the American College of Surgery and the American Association of Nurse Anesthetists, have issued position statements regarding the use of mobile devices.

So how is this technology affecting your medical practice and how will you control the use of personal electronic devices in your medical setting? The first step is to educate clinicians and staff regarding the dangers of non-essential use of devices and the significant patient safety lapses they can cause. The next step involves an assessment of the potential risks based on the usage behaviors and patterns of your healthcare professionals. The results of your assessment will drive the policies needed, and those policies should clearly define what is acceptable behavior, what is unacceptable behavior and the consequences for breaching the policy.

# 2018 Cybersecurity Outlook

Looking ahead to 2018, cybercriminals will redouble their efforts to steal personal health information (PHI). The number of ransomware attacks has steadily risen for the last few years, and there is no indication that it will slow anytime soon. Reliance upon technology in healthcare continues to grow, providing cybercriminals more means to access more data. By its very nature healthcare is more susceptible to cybercrime than other industries. There is some good news, however; with education and the right resources, today's physicians and their practices can be better equipped to prevent a security breach or handle one should it occur.

The healthcare industry is particularly vulnerable to cyberattacks for a number of reasons. One example is the use of mobile devices by doctors, such as phones and tablets, which contain and manage patient data. According to Adi Sharabani in his article "Mobile Security Trends in Healthcare" on Skycure.com, 65% of physicians send PHI via text message, and over 70% of physicians were using a mobile device to aid their practice as of 2015. Certainly, these numbers are higher in 2018. These devices are not only easier to lose or have stolen, but when they are offsite, many of the security measures provided by a secure in-office network do not protect them.

Like everyone, the healthcare industry is becoming increasingly reliant on technological devices. From insulin pumps delivering a steady stream of insulin to diabetics and wearable trackers monitoring blood pressure and heartrate, to a radiologist in Australia reading the radiograph of a patient in East Tennessee, technology utilization has burgeoned over a short period. For many people, it is difficult to imagine life without these conveniences. Nevertheless, the devices and technologies we use constantly are all vulnerable to cyberattacks that could put them out of commission.

While cybercriminals continue their targeted and increasingly sophisticated attacks on the healthcare industry, physician practices can get smarter and more prepared. Some of the ways to be better equipped to prevent a cyberattack in 2018 are:

1. Back up your data - the more frequently the better
2. Protect your equipment offsite as well as onsite
3. Offer multiple training courses for employees in order to keep them aware of the evolving tools used by cybercriminals
4. Do not become complacent with security and authorization procedures
5. Update your hardware and software when updates are available
6. If you do fall victim to a breach, promptly notify the affected parties.

Lastly, even when you do everything you can tactically to secure your data, it is best to have cybersecurity insurance to protect your practice – just in case.

SVMIC's medical professional liability policy includes $50,000 of cybersecurity coverage

with NAS to assist in mitigating the damages associated with a security breach. Using SVMIC's website, policyholders can access multiple online resources, which provide tools such as monthly cybersecurity updates, webinars and online training and support. In addition, SVMIC's Medical Practice Services offers consulting and training related to cybersecurity and HIPAA.

# The MIPS Cost Category: New for 2018

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

In 2018, the federal government began to assess the cost of caring for Medicare beneficiaries under the Merit-based Incentive Payment System (MIPS). One of four components of the MIPS composite performance score – the cost category – counts as 10% of the overall score in 2018. While it may have a limited influence on performance this year, this component will rise to 30% of the score in 2019. Therefore, it is crucial to understand how the government is measuring costs under this program.

First, it's important to recognize that participating physicians and advanced practice providers will not report any data for the cost measure. Rather, the Centers for Medicare & Medicaid Services (CMS) will analyze costs based on claims submitted to Medicare.

There are two elements being captured for the cost category: (1) Total Per Capita Costs for All Attributed Beneficiaries (TPCC); and (2) Medicare Spending Per Beneficiary (MSPB). The first element, according to CMS, is a "payment standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians." The second "assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's [acute inpatient] hospital stay." MSPB is also standardized and risk-adjusted, although there is no specialty factor.

While there are details related to each of the elements, perhaps the most crucial is to whom – and how – the costs are attributed. Let's break down the attribution for each element:

Total Per Capita Costs for All Attributed Beneficiaries (TPCC). The TPCC examines costs at a global level; namely, the government's cost of providing care to the patient during the entire reporting period, which is defined as the calendar year. The means for attributing the patient to a physician is somewhat complicated, however. CMS looks initially to whether the patient received a primary care service from a physician care practitioner (PCP). PCPs are defined by their taxonomy code: General Practice (01); Family Practice (08); Internal Medicine (11); Geriatric Medicine (38); Clinical Nurse Specialist (89); Nurse Practitioner (50); and Physician Assistant (97). If the patient received the service from one of these practitioners, the entire cost of caring for that beneficiary for the year is attributed to that practitioner.

If the patient did not receive the service from a PCP during the reporting year, however, the costs are attributed to the non-PCP who performed the plurality of primary care services. Primary care services include evaluation and management services provided in office and other non-inpatient and non-room settings, as well as initial Medicare visits and annual wellness visits.

For the TPCC element, it is crucial for PCPs to be aware of how, when and where their patients access care. For specialists, it's absolutely critical to ask every Medicare patient if and when they have seen their PCP. This must go beyond "do you have a PCP?" as simply having one won't help with the program; the patient must have seen the PCP in the office, nursing facility or home as Medicare will not be aware unless there was a claim generated. Furthermore, specialists who use advanced practice providers (APP s) to bill independently must be aware that patients may be attributed to them as the government is not crosschecking the name of the practice in which the APP works to determine whether or not it's a primary care practice. For example, if an Endocrinology practice designates a nurse practitioner to see established patients and bills for him or her as an independent practitioner, it's highly likely that the patients' costs will be attributed to the APP or practice (depending on whether individual or group reporting is chosen ).

Finally, physicians who may not consider themselves as "PCPs," but who are registered with CMS under one of the aforementioned seven taxonomy codes, will be considered PCPs under the initial attribution step. This may impact Urgent Care physicians, for example, as well as those specialty physicians who may have been registered under "Internal Medicine," perhaps even unknowingly. As noted, CMS is not considering the practice's name or how it identifies itself; if the practitioner is credentialed as one of those seven taxonomy codes, he or she is considered a PCP under this program and will have patients' cost attributed to him or her.

Medicare Spending Per Beneficiary (MSPB). The MSPB episode includes all Medicare Part A and Part B claims falling in the episode "window," specifically claims with a start date between three days prior to a hospital admission through 30 days after hospital discharge. However, the costs for the episode are attributed to the physician who has the plurality of Part B services *during* the index admission. The index admission is the period between admission date and discharge date of the hospital stay, inclusive. Given the

calculation, it's likely that the surgeons and proceduralists will get hit with these episodes, if applicable; if not, it will most commonly be the physician who is managing the patient's care.

For both measures, plurality is defined by payments standardized to the Medicare allowable. Part D-covered prescription drug costs are not counted for either measure; and the program only incorporates traditional Medicare patients. Those patients enrolled in Medicare Part C (Medicare Advantage plans) are not included. Furthermore, if a patient dies during the reporting episode, he or she is excluded from the data.

Finally, the case minimum for reporting is 20 episodes, regardless of reporting level. This means that if four physicians report as a group, the minimum is 20 episodes among all four; if that same group reported separately, *each* of the four physicians would need the minimum 20 episodes to trigger reporting.

The cost category mirrors the assessment made under the Value-based Payment Modifier Program. Although the program ended on December 31, 2016, it issued insightful reports called "QRURs" - Quality and Resource Use Reports, most recently in September 2017. Understanding how you'll be assessed, as well as obtaining and reviewing your QRUR, is vital to preparing for success under the new category of MIPS in 2018.

For additional resources, please see the article "2018 Penalties: PQRS and VBPM Informal Review Available through December 1", originally published in the October 2017 edition of The Sentinel.

For more information, see 2018 Cost Measures

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