The Patient Who Cried Wolf

By Tim Behan, JD

We are all familiar with Aesop's fable wherein a lonely shepherd boy seeks attention by crying out wolf. This trick brings villagers rushing to his side to protect the flock of sheep from an attack. But there is no wolf the first few times the boy shouts out this false alarm. When a real wolf does appear, the villagers do not believe the boy and thus do not come to his aid. As we know, the wolf inflicts great damage to the flock because the villagers believe the boy is lying once again. In the medical field, we are faced with these types of patients every day, whether they are seeking attention, or something more, with what we may perceive to be lies. They cry wolf and we tire of their false tales. But unlike the villagers who suffer no harm from the boy's lies, we in the health care field must fully inquire every time a patient raises an alarm. Failing to do so greatly increases the risk that we will become the sheep at the mercy of the medical malpractice wolf.

This truth is evidenced by a case SVMIC defended a few years ago. A 40-year-old female with a history of lower back issues and drug seeking behavior presented to a somewhat rural emergency department where everybody was well familiar with her frequent attempts to secure narcotics. This was her fifth visit in four months. On this particular presentation, she gave a history of sharp pain; almost like being stabbed in her spine, after trying to pick up a heavy object at home earlier that day. The patient was a bit more hysterical than usual and the doctor was having a difficult time assessing her. The doctor was eventually able to conduct a physical exam. This exam did not include ambulating or obtaining any images. The patient was uncooperative and seemed to be upping the ante for drugs by complaining of great pain out of proportion to the physical findings. The doctor documented the exam as essentially normal. A non-narcotic pain reliever was prescribed, instructions were given, and the patient was discharged.

When an ED nurse came to the exam room to ready the patient for home, she found her on the floor complaining that her legs were numb and that she was having trouble walking. The nurse assisted the patient to the wheelchair and rolled her to a waiting vehicle. During this short trip, the patient reported that she had urinated all over herself and needed to go back inside the hospital. It appeared to the nurse that this was a last ditch attempt to get stronger pain medication. The patient was told that her neurologic exam was normal because the doctor saw the patient move her legs in the exam room and thus there was no need for further evaluation. While the nurse did note the complaints of numbness and alleged incontinence, this information did not make it back to the doctor. A few days later, well past 72 hours from the initial incident at home, the patient went to a different facility. There a CT and follow-up MRI were ordered. The patient was diagnosed with a large lumbar disc rupture resulting in cauda equina syndrome. Surgical intervention occurred,

but it was too late to reverse the significant neurologic deficits.

As expected, a lawsuit was filed against the doctor and the hospital. The main allegations against the doctor were for failure to: perform a more thorough examination, order diagnostic studies, refer to a neurosurgeon, and to stabilize the patient before discharging her home. The hospital was accused chiefly of EMTALA violations. A vigorous defense was attempted, but it was clear based on the actions and inactions of all involved, that the patient's complaints were not taken seriously. Everyone believed she was lying to get narcotics. She cried wolf one too many times, the villagers did not come to her assistance, and the medical malpractice wolf ate heartily to the tune of a substantial settlement from all involved.

"A liar will not be believed, even when he speaks the truth." Aesop

Memphis Maxims

By Hugh Francis III, MD

At the UT College of Medicine, rising third-year medical students usually begin their clinical rotations during the first week of May. In preparation, UT has historically educated these students in risk management, where they learn, among many other things, the importance of their patients' knowing, trusting, and liking them. The students are taught the value of common courtesy in showing a patient how deeply he or she is cared about and valued. These "Memphis Maxims" were developed to guide the medical students toward success in patient care, beginning with that first encounter. We thought they would be of interest to all our policyholders, so Dr. Francis has kindly allowed us to share them with you in The Sentinel.

- Enter the room with a smile. Make eye contact with and address everyone in the room: patient, family, and visitors alike.
- Sit down. This makes you appear unhurried and allows you to communicate on the same eye level without looking down on the patient.
- Ask questions and LISTEN to the answers. Do not interrupt very often.
- Touch the patient where the problem is. No visit should end without having touched the patient.
- Do charting or computer entry at the bedside when possible. This extends visit time and is perceived by the patient as added encounter time.
- Never talk with your hand on the door knob.
- Leave the door open or closed and the lights on or off as the patient prefers. The patient might remember this the most about your visit.

Quietly Improving Care with QICs

By Justin Joy, JD, CIPP

Just as physician-patient confidentiality encourages frank discussions between the physician and the patient about the patient's condition without concern of involuntary disclosure of that information, documents generated within the parameters of a quality improvement committee ("QIC") encourage medical practices to take a candid look at how they can improve patient care and compliance. As recognized by policymakers, QICs can lead to improvements in healthcare quality and processes but, in order to encourage effective evaluations leading to these advances, certain protections should be made available to physicians and entities engaging in these efforts.

Documents created in connection with the activities of a properly established QIC typically receive confidentiality protection from civil subpoenas and discovery in litigation. An understanding of the definitions of the various components of a QIC are important and vary state-by-state. In Tennessee for instance, a quality improvement committee (formerly known as a peer review committee), is defined as: "a committee formed or retained by a healthcare organization, an activity of a healthcare organization, or one (1) or more individuals employed by a healthcare organization performing the types of [specified] functions . . . the purpose of which . . . is to evaluate the safety, quality, processes, costs, appropriateness, or necessity of healthcare services." In order to meet the definition of a QIC, the committee must engage in specified activities such as determining whether health services provided were performed in compliance with applicable standards of care, evaluating the qualifications and performance of healthcare providers, taking action upon matters relating to provider discipline, and undertaking activities to determine the healthcare organization's compliance with state or federal regulations.

Many other states including Alabama, Arkansas and Kentucky have similar statutes providing for the protection of records relating to healthcare quality improvement efforts under certain specified circumstances. QICs may be referred to by other names such as a peer review committee or professional standards review committee.

In addition to understanding what qualifies as a QIC, it is also important to understand what documents and records are privileged and subject to confidentiality protection. In Tennessee, a "record" is defined as "records of interviews and all reports, incident reports, statements, minutes, memoranda, charts, statistics, evaluations, critiques, test results, corrective actions, disciplinary actions and any and all other ***documentation generated in connection with the activities of a QIC*** ". There is a sometimes confusing but important distinction regarding which records reviewed by a QIC are protected and which ones are not. Information and records, which are not produced for use by a QIC or created by

persons acting on behalf of a QIC and are otherwise available from an independent or original source, are not privileged from discovery. In other words, if a record or document came into existence independent of the QIC's activity, it is subject to discovery despite the fact that it may have been presented during the proceedings of a QIC.

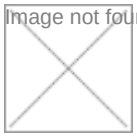
In terms of best practices, QICs should be established and maintained pursuant to a written policy based upon the definitions and parameters set forth in state law. Some states, such as Arkansas, require that QICs be organized by, and operated pursuant to, a written plan or policy. Among other items, the policy should address the membership of the QIC, the activities of the QIC, how records are generated by or on behalf of the committee, and that the information and records of the committee's activities shall remain confidential.

Finally, and perhaps most importantly, the information and records of a QIC need to be kept private within the confines of a QIC. While it may be tempting to tout successes from a QIC, doing so, even within the broader organization that established the QIC, may waive the confidentiality protection provided to the committee's information. QICs can result in improvements to patient care and compliance but it's best to keep the details of such efforts within the QIC. SVMIC recommends that practices consult their own healthcare attorney when establishing a QIC to ensure they have taken appropriate actions to ensure that the work of the QIC will not be discoverable.

An Analysis of Emergency Medicine Closed Claims

By Carolyn Akland, MBA, RN, CPHQ, LNCC

A review of SVMIC emergency medicine closed claims from 2006 – 2016, where a loss was paid on behalf of an insured, reveals four basic areas that contributed to the indefensibility of the claims as seen in the chart below.



DOCUMENTATION ISSUES: Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. As the graph above illustrates, documentation issues were a factor in 49% of claims paid for EMDs (emergency medicine doctors). The majority of the cases involved inadequate documentation, which can negatively influence the ability to defend the care provided to a patient. Most often, there was a failure to document a history, the extent and details of an examination, the main points discussed during phone calls and the specific warning symptoms that should provoke return to the emergency department (ED) immediately.

In one case, a 40-year-old male presented to the ED with sudden complaints of testicular pain and swelling. The EMD diagnosed epididymitis, prescribed Bactrim and Lortab and instructed the patient to follow up with his PCP in 2 days. Within 2 days, the patient returned with testicular torsion requiring an orchiectomy.

Expert review found that the physical exam was insufficient to rule out torsion. Such expert review likewise found fault with the EMD's management in failing to obtain a urology consult or ultrasound. Further complicating the defensibility of the case was the very short length of time from when the EMD first went into the patient's room, completed the exam, wrote out the discharge prescriptions and documented the visit – only 8 minutes. All of this gave the appearance that the EMD performed a perfunctory exam at best and missed the opportunity for timely diagnosis and intervention.

Another case involved a 2-year-old male who was brought to the ED by his parents who reported an unwitnessed ingestion of two oxycodone 10 mg tablets. The EMD sought advice from the poison control center (PCC) and the child was observed for 3 hours. The child appeared playful and exhibited no alarming symptoms during the 3 hour observation so he was discharged home. The parents found him unresponsive 10 minutes after arriving home. He was resuscitated, but never regained consciousness and eventually expired after transfer to a tertiary care hospital. An autopsy revealed oxycodone

intoxication. Defense review was critical of the EMD's failure to administer activated charcoal as a precaution, failure to obtain a urine drug screen and failure to notify the parents of what symptoms to be alert for upon discharge. PCC records were obtained which indicated they had advised the EMD to monitor the child for 12-18 hours; this was difficult to overcome as the EMD failed to document what information was exchanged during his call with them.

COMMUNICATION ISSUES: Communication breakdowns occurred in almost a third of the claims reviewed, with half of these occurring between the EMD and the patient. Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in patients' perception of their quality of care. Small steps taken, such as a warm introduction to the patient as well as the family and asking permission to interview and examine the patient with others present, can place the patient at ease in an otherwise stressful situation. Using open-ended questions and giving them an opportunity to ask additional questions can improve the accuracy of information obtained and increase the likelihood of compliance.

Several of the cases reviewed included the allegation of lack of informed consent. One example involved a 60- year-old man who was administered Imitrex in the ED for a severe headache. Shortly after the injection, he suffered an acute myocardial infarction, requiring emergent cardiac catheterization with stent placement. The plaintiff argued that the EMD was negligent in his superficial examination of the patient and in failing to advise of potential risks and complications associated with the Imitrex. The failure of the EMD to document a cardiac medication (the patient was taking Plavix) and smoking history, along with the failure to document that any risks were discussed, resulted in settlement of the case.

An example of a case involving a communication breakdown between the EMD and a Physician's Assistant (PA) involved a 55-year-old male who underwent a lumbar epidural steroid injection at a pain management center. Eleven days later, he presented to the ED via ambulance complaining of fever off and on since the steroid injection, back pain and a loss of bowel and bladder function. The triage nurse noted leg weakness, 700 cc's urine upon catheterization and a pulse rate of 130. A PA recorded a limited physical exam and failed to note lower extremity strength, reflexes, gait, straight leg raising or sensation. The PA also deferred a rectal exam. A urinalysis was negative, a white blood cell count was 24,000 and the sedimentation rate was elevated. The PA diagnosed a urinary tract infection, prescribed antibiotics and discharged the patient. The patient returned to the ED the next day and underwent an MRI, which revealed an epidural abscess necessitating an emergency laminectomy. Because of the alleged delay in diagnosis, the patient was confined to a wheelchair and incontinent of bowel and bladder function. Among those sued were the PA and EMD. Defense experts were critical of the ED visit, specifically a negative UA that did not support the diagnosis of UTI, an inadequate exam of the patient's extremities, and failure to include spinal epidural abscess in the differential diagnosis. Plaintiff's experts made the argument that this patient was one that was outside the PA protocol and required either a discussion with, or an exam by, the EMD prior to discharge.

SYSTEMS ISSUES: Systems issues were present in 15% of the claims. Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanisms alone. Failure to follow up on abnormal test results or vital signs were common problems noted in the case review.

This point was illustrated in a case involving a 21-year-old female seen by her PCP with complaints of a cough, shortness of breath and chest tightness for 3 weeks. Her pulse was 108. She was diagnosed with bronchitis and treated with an antibiotic. One week later, she presented to the ED with complaints of hemoptysis, cough and shortness of breath. Her resting pulse was 118. A chest x-ray was performed but was not reviewed by the EMD, and the findings of biventricular cardiac enlargement consistent with cardiomyopathy went unnoticed. The radiologist's call to the ED nurse to communicate unexpected findings was not communicated to the EMD. The patient was diagnosed with persistent bronchitis and sent home. The next day she presented to her PCP's office with worsening symptoms, significantly hypotensive and tachycardic. She was sent to the ED. Upon arrival, she arrested, was resuscitated and admitted to the critical care unit where she developed Acute Respiratory Distress Syndrome (ARDS), multi-organ system failure and expired. The EMD was among those sued. A review of the case revealed two primary system failures by the EMD: failure to follow-up on abnormal vital signs (including tachycardia) and failure to follow up on the abnormal CXR. Multiple indefensibility factors arose which led to settlement; including failure to obtain a CT of the chest and failure to review the CXR, either of which would have led the physician to admit the patient for further evaluation and treatment.

Lessons Learned:

- Personally obtain a complete history and perform a physical exam to include a review of systems, social history and past medical history.
- Document the details of all in person and telephone conversations regarding patient care.
- If medications or other history is not available upon admission and the patient/family are poor historians, document such along with your efforts to obtain that information. Document that you sought old charts and diagnostics for comparison when applicable. Note the actual chart dates reviewed rather than simply stating that you "reviewed the old chart".
- If your observations differ from nursing documentation, verbally communicate with the staff to attempt to reconcile the findings.
- Ensure appropriate oversight of advanced practice providers (APP).
    - Have a clear system that identifies which physician is responsible for supervising each APP shift and have written protocols that address the types of patients who APPs can see independently and which types of patients seen by the APP require EMD consultation prior to discharge.
    - Prior to signing any APP note, the EMD should read it in its entirety to verify accuracy.
- Clearly and timely, communicate/document information about patients with anticipated problems, including your treatment plan, to covering EMD's.If your treatment plan deviates from any local community standard or nationally recognized guidelines for your specialty, document your rationale for doing so.
- Minimize the risks at discharge:
    - Address any abnormal tests and discuss the pertinent follow-up necessary with the patient and with their PCP. Document these discussions to include the physician by name and the essence of the call.
    - Review vital signs prior to discharge and document the rationale for proceeding with discharge if abnormal or not improved.
    - Document the discussion you had with the patient regarding your findings and plan of treatment.
    - Discharge instructions should include:
        - actionable follow-up care instructions that are time-specific (e.g. 2-3 days) and include the doctor's name and phone number,
        - specific warning symptoms that should provoke return to the ED immediately,
        - encouragement to return to the ED if they experience any problems (e.g. follow-up physician will not schedule, etc.), and
        - specific warnings (e.g. dangers of driving or drinking alcohol).
    - Clearly communicate to the patient the importance of keeping a follow-up appointment with the PCP.
    - Have a mechanism in place to track lab tests pending at discharge and to notify discharged patients of discrepancies or the need for a change in the treatment plan.

- Give the patient a copy of instructions.
- Arrange for the discharge summary to be sent to the PCP in a timely manner. If the patient has no PCP and follow-up is warranted, work with hospital professionals to arrange follow-up care and communicate the discharge summary to those providers.

Social Security Number Removal Initiative Reminder: Get Your Systems Ready

By Elizabeth Woodcock, MBA, FACMPE, CPC

As you know, beginning in April 2018, CMS will start mailing Medicare cards with new Medicare Beneficiary Identifiers (MBIs) to all individuals covered by Medicare. The MBI will, after a transition period, replace the Social Security Number (SSN)-based Health Insurance Claim Number for transactions such as billing, eligibility status, and claim status. Make sure your systems are ready:

- Visit Medicare Learning Network's (MLN) Social Security Number Removal Initiative (SSNRI) Home and Provider webpages for the latest details about the transition. Subscribe to the weekly MLN Connects newsletter for updates and new information.
- Verify your patients' addresses. Your patients will not get a new card if their address is not correct. If the address you have on file is different from the Medicare address shown in electronic eligibility transaction responses, ask your patients to correct their address in Medicare's records through Social Security. This may require coordination between your billing and office staff.
- Attend MLN's quarterly calls to get more information. MLN will let you know when calls are scheduled in MLN Connects.
- Work with MLN to help your Medicare patients with the change to the MBI. This fall (2017), MLN will be in touch with ways to help.
- Get ready to use the new MBI Format. Ask your billing and office staff if your system will be ready to accept the 11 digit alpha numeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change. Make and internally test changes to your practice management systems and business processes by April 2018, before CMS mails the new Medicare cards.
- If you are a vendor who partners with Medicare providers to bill Medicare, communicate with them about your system readiness and what they should expect to see from you beginning April 2018.

Meaningful Use Deadline Looming

By Elizabeth Woodcock, MBA, FACMPE, CPC

July 1, 2017, is the deadline for physicians to submit a hardship application for the 2018 payment adjustment, based on the 2016 reporting period for the EHR Incentive Program. If you were eligible to participate in the program, but you did not successfully report the program's required "meaningful use" criteria for 2016 by the deadline, it's vital to apply for the hardship. Hardship is granted on an annual basis, so you must apply again even if you were granted the hardship in the past. Although there are multiple criteria for the hardship, most physicians can meet the hardship definition : "…extreme and uncontrollable circumstances in the form of issues with the certification of the EHR product or products such as delays or decertification, issues with the implementation of the CEHRT [certified electronic health record technology] such as switching products, or issues related to insufficient time to make changes to the CEHRT to meet CMS regulatory requirements for reporting in 2016."

The application, which only takes a few minutes to complete, must be submitted electronically by July 1, 2017 – or faxed on or before that date. These five minutes will save you thousands of dollars in penalties, as the Centers for Medicare & Medicaid Services (CMS) will apply a 3% penalty to all of your Medicare reimbursement in 2018 to those who fail to participate successfully or are not granted the hardship.

Access the application here.

Meaningful Use: What's the Deal?

Many of you may be asking why we are still covering the EHR Incentive Program. There is significant confusion about this topic among physicians, administrators and EHR system vendors. Based on the recommendation of their vendor for "new" criteria, I have personally witnessed practices that have jumped through hoops unnecessarily. Before you take the opportunity to address meaningful use in 2017, it pays to review the facts:

1. The EHR Incentive Program for Medicare sunset on December 31, 2016. The program closed its doors. The hardship application is due on July 1, 2017, because of the two-year gap between the "performance" year – in this case, 2016 – and the "adjustment" year – 2018. The hardship is based on your 2016 performance, when the program was still up and running.
2. Although the program halted in 2016, the new Merit-based Incentive Payment System (MIPS) incorporates most of the criteria through the Advancing Care Information (ACI) category. Although it's called a new name, you'll recognize the reporting requirements immediately as they are simply a variation of the historical

meaningful use criteria. The 2017 program requirements for ACI can be accessed via this link.

3. The EHR Incentive Program for Medicaid is still alive and kicking. Indeed, it has five more years of participation. The Centers for Medicare & Medicaid Services (CMS) remains committed to the program, although 2016 was the final year to start it. Therefore, only those physicians and advanced practice providers who enrolled in 2016 – or prior to 2016 – are eligible to continue. Note that only providers who saw 30% or more of their patient volume as Medicaid beneficiaries are eligible, with the bar lowered for pediatricians to 20%. The 2017 program requirements can be accessed via this link. The current EHR reporting period is a minimum of any continuous 90-days between January 1 and December 31, 2017. This program does not have any penalties associated with it; however, each provider is eligible for an $8,500 annual bonus. Importantly, you can "skip" reporting periods under this program so even if you started in 2013 – and never reported in the interim – you can pick back up in 2017 and still gain your bonus payment.
4. Hospitals, which may be your employer or a partner as you navigate the reimbursement landscape, are still participating in the EHR Incentive Program. The program has not shut down for hospitals, which continue to be required to participate by submitting the meaningful use criteria.

Given the fact that the EHR Incentive Program has been altered based on participation status, it's important to clarify any communication about the program, as well as EHR system updates and upgrades, with your vendor. Because compliance depends on where you stand – MU for Medicare, MIPS ACI, MU for Medicaid, or an Eligible Hospital – it pays to understand the ground rules to avoid investing time in unnecessary activities.

ABN Update

It is time to update your Advance Beneficiary Notice of Noncoverage (ABN). This important form issued by the Centers for Medicare & Medicaid Services (CMS) is used to communicate with patients about services for which Medicare payment is expected to be denied. The changes as of June 21, 2017 include a new expiration date on the document (March 2020), as well as information for patients about their rights to non-discrimination practices. The form also includes information about requesting the ABN in an alternative format. Learn more about changes and download the new forms in English and Spanish here.

Business Suit or Hazmat Suit? Which Do I Wear When Visiting Your Practice?

By Rana McSpadden, FACMPE

The first visual impression a patient has of a medical practice is the lobby. Do you know what impression you are making on your patients? As a medical practice consultant, I have seen my share of lobbies through my travels. As a patient, I can recall a time that the lobby was so inviting and comfortable, I did not mind that I had to wait an hour-and-a-half before I went back to see the doctor.

For every nice lobby I have encountered, I have been in plenty that made me feel I needed a tetanus shot as soon as I walked in the door. I have seen paint peeling off the walls, mold growing on ceiling tiles, and chair upholstery ripped to the point where the foam was visible. There have been broken chairs with signs that say “broken” with patients still sitting in them because there were no other seats available. I have seen tile floors caked with so much dirt I could not tell the original tile color, and carpets so stained they were black. I have been in restrooms with no toilet paper and/or paper towels and garbage cans overflowing with trash. The reception windows and walls had signs and papers haphazardly taped everywhere, many of which were outdated, torn or discolored with age.

When I have spoken with a manager or a doctor about creating an inviting lobby, the response I usually receive is they cannot afford fancy lobbies. What many practices fail to understand is they do not need to spend a lot of money with waterfalls, fish tanks, or other amenities. A practice can create a comfortable environment with just the basics. Listed below are tips on creating a comfortable and clean environment.

Daily:

1. Before the practice opens, go out to the lobby and ensure it is neat and tidy. Vacuum carpeted surfaces or sweep tiled/hardwood services.
2. Straighten magazines and place strategically throughout the lobby.
3. Ensure garbage cans are empty and have fresh liners.
4. Stock water/coffee station (if provided) with cups and supplies.
5. Ensure the lobby restroom(s) is clean, fully stocked with toilet paper, paper towels, and soap and the garbage can is empty and has a fresh liner.
6. Check the neatness of the lobby and restroom(s) routinely throughout the day and clean/re-stock as necessary.

7. After doing steps 1-6, open the doors to invite in patients. If you have two doors, don't frustrate patients by locking one of them.

Magazines: Make sure all magazines are current (within 1-2 months). Toss any magazine that becomes tattered prior to its scheduled toss date. Have a good selection for both men and women. Be cautious of the types of articles or the "tone" of the magazine. For example, articles headlines like "How to Sue Your Doctor" are not what you want in your lobby.

Furniture: Chairs should be comfortable and well maintained. Remove or repair any broken chairs immediately. Broken chairs are a liability if a patient is injured. Have upholstered chairs routinely (at least annually) cleaned by professionals. Spot clean between routine cleanings unless stained with body fluids, in which case, have professionals clean it. If bodily fluids are a constant issue due to the nature of the patients, consider vinyl chairs for ease of cleaning and disinfection. Have a few oversized chairs for obese patients.

Flooring: Carpet is a great noise reducer and creates a warm environment, but is easily soiled. Routinely have carpets professionally cleaned (every 6 months or at a minimum annually). Like with the furniture, small stains can be spot cleaned between scheduled cleanings. For stubborn stains or bodily fluids, call a professional carpet cleaner. If the floor is a hard surface, such as wood or tile, have professionals regularly strip, wax, and buff these surfaces. Without routine maintenance, these surfaces look grimy and scuffed, even with regular mopping. Look for, and be cautious of, standing water that can be a slip hazard. Entrance mats help reduce the amount of water coming in on patients' feet, but be sure these mats are large and heavy enough that they do not become a slip/trip hazard themselves.

Signs/Posters: There are many posters practices are required by law to display. Additionally, there are signs practices choose to display regarding co-pays, insurance, etc. Designate one area of the lobby to display all signs and posters. If possible, frame or laminate these signs to maintain a clean, uniform look. At a minimum, replace signs and posters if they begin to curl, show discoloration, become outdated or torn. Contact Medical Practice Services at SVMIC for a list of required posters for your state.

Plants: Live plants present a more natural feel than fake ones. Be sure to regularly water and cut off dead leaves because there is nothing worse than a dead plant in the lobby. Dead plants may lead patients to associate a practice's lack of care for their plants as lack of care for their patients. If the practice is unable to maintain healthy plants, hire a company that specializes in maintaining plants for businesses. Some companies even provide their own plants and switch out any that become sick. If live plants are not an option, use silk plants, but regularly dust the leaves. Dusty fake plants are the equivalent of dead real plants.

Television/Music: When it comes to offering patients the option to watch television, be cautious of the content. Televisions should be set on channels where programming is

appropriate for the population and will not likely offend anyone. It is probably best not to display court or reality shows with lots of drama. Also, be cautious of those “free” televisions that run advertising all day, including advertisements by local personal injury attorneys. If patient wait times routinely run long, patients will hear the same message repeatedly. They may begin timing their wait based on how many times they hear the same message, and the item meant to distract them from their wait actually begins to draw their attention to how long they have had to wait. If having a television is not an option, consider playing music in the lobby. Playing a local radio station is free, but if using a streaming service such as Pandora, Spotify, or satellite radio, there are typically special accounts businesses must purchase to use these services.

Just as your staff are a representation of the care you deliver, so is your office environment. With planning and care, a practice can easily create a lobby that projects a welcoming atmosphere. There is only one chance to make a first impression, so make it an inviting one.

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Meaningful Use Deadline Looming

By Elizabeth Woodcock, MBA, FACMPE, CPC

July 1, 2017, is the deadline for physicians to submit a hardship application for the 2018 payment adjustment, based on the 2016 reporting period for the EHR Incentive Program. If you were eligible to participate in the program, but you did not successfully report the program's required "meaningful use" criteria for 2016 by the deadline, it's vital to apply for the hardship. Hardship is granted on an annual basis, so you must apply again even if you were granted the hardship in the past. Although there are multiple criteria for the hardship, most physicians can meet the hardship definition : "…extreme and uncontrollable circumstances in the form of issues with the certification of the EHR product or products such as delays or decertification, issues with the implementation of the CEHRT [certified electronic health record technology] such as switching products, or issues related to insufficient time to make changes to the CEHRT to meet CMS regulatory requirements for reporting in 2016."

The application, which only takes a few minutes to complete, must be submitted electronically by July 1, 2017 – or faxed on or before that date. These five minutes will save you thousands of dollars in penalties, as the Centers for Medicare & Medicaid Services (CMS) will apply a 3% penalty to all of your Medicare reimbursement in 2018 to those who fail to participate successfully or are not granted the hardship.

Access the application here.

Meaningful Use: What's the Deal?

Many of you may be asking why we are still covering the EHR Incentive Program. There is significant confusion about this topic among physicians, administrators and EHR system vendors. Based on the recommendation of their vendor for "new" criteria, I have personally witnessed practices that have jumped through hoops unnecessarily. Before you take the opportunity to address meaningful use in 2017, it pays to review the facts:

1. The EHR Incentive Program for Medicare sunset on December 31, 2016. The program closed its doors. The hardship application is due on July 1, 2017, because of the two-year gap between the "performance" year – in this case, 2016 – and the "adjustment" year – 2018. The hardship is based on your 2016 performance, when the program was still up and running.
2. Although the program halted in 2016, the new Merit-based Incentive Payment System (MIPS) incorporates most of the criteria through the Advancing Care Information (ACI) category. Although it's called a new name, you'll recognize the reporting requirements immediately as they are simply a variation of the historical

meaningful use criteria. The 2017 program requirements for ACI can be accessed via this link.

3. The EHR Incentive Program for Medicaid is still alive and kicking. Indeed, it has five more years of participation. The Centers for Medicare & Medicaid Services (CMS) remains committed to the program, although 2016 was the final year to start it. Therefore, only those physicians and advanced practice providers who enrolled in 2016 – or prior to 2016 – are eligible to continue. Note that only providers who saw 30% or more of their patient volume as Medicaid beneficiaries are eligible, with the bar lowered for pediatricians to 20%. The 2017 program requirements can be accessed via this link. The current EHR reporting period is a minimum of any continuous 90-days between January 1 and December 31, 2017. This program does not have any penalties associated with it; however, each provider is eligible for an $8,500 annual bonus. Importantly, you can "skip" reporting periods under this program so even if you started in 2013 – and never reported in the interim – you can pick back up in 2017 and still gain your bonus payment.
4. Hospitals, which may be your employer or a partner as you navigate the reimbursement landscape, are still participating in the EHR Incentive Program. The program has not shut down for hospitals, which continue to be required to participate by submitting the meaningful use criteria.

Given the fact that the EHR Incentive Program has been altered based on participation status, it's important to clarify any communication about the program, as well as EHR system updates and upgrades, with your vendor. Because compliance depends on where you stand – MU for Medicare, MIPS ACI, MU for Medicaid, or an Eligible Hospital – it pays to understand the ground rules to avoid investing time in unnecessary activities.
