The Tale of Two Appendectomies

By Kathleen W. Smith, JD

Appendicitis is a well-known medical condition. According to the National Institutes of Health, five to nine people out of every 100 will develop appendicitis during their lifetime.[1] It is most common in younger patients, teenagers, and individuals in their 20s, but appendicitis can happen to patients of any age. *Id.* It is the most common cause of acute abdominal pain requiring surgery. *Id.* Although appendicitis and appendectomy are common medical events, they are generally understood to be once-in-a-lifetime medical events. The patient in this closed claim, however, required *two* appendectomies. Her medical misadventure provides us with several helpful lessons on the important topic of medical documentation.

On February 3, 2014, Mrs. Green developed acute abdominal pain. She presented to the Emergency Department of her local hospital and, after examination and imaging, was diagnosed with appendicitis. Her care was referred to the on-call general surgeon, Dr. Blue, who was able to schedule Mrs. Green for an appendectomy that day. Intra-

operatively, Dr. Blue found a severely inflamed abdominal cavity. The surgery took twice as long as is customary for Dr. Blue's appendectomies. Regardless, Dr. Blue was able to perform the surgery without apparent complication and discharged Mrs. Green home the next day.

After discharge, Mrs. Green was followed closely by Dr. Blue in his office for waxing and waning complaints of abdominal pain, nausea, and fever. Mrs. Green returned to Dr. Blue for seven post-operative follow-up appointments throughout February and March. She was prescribed several courses of antibiotics.

Before Mrs. Green's third office visit, Dr. Blue received the surgical pathology report from the appendectomy. The report found "acutely inflamed fibroadipose tissue" but "no appendiceal architecture within the resection." The report was filed in Mrs. Green's office chart but was not signed, initialed, or dated by Dr. Blue. During the third office visit, Dr. Blue discussed the findings from the pathology report with Mrs. Green and recommended returning her to surgery. Mrs. Green, feeling better by this time and recovering well from the appendectomy, was reluctant to undergo a second operation. She advised Dr. Blue that she preferred to wait and let a little more time pass, but she agreed to revisit his recommendation at her next appointment. Dr. Blue, through the scribe he used to assist with his medical record preparation, documented in the visit note that Mrs. Green was "advised to go back in with laparotomy and check to see if anything is wrong, but patient requested not to do anything until the next office visit."

Dr. Blue raised the issue again with Mrs. Green during an appointment in March. By this time, her complaints were very mild and almost fully resolved. Mrs. Green also had a spring vacation planned for the following month that she was looking forward to taking. Mrs. Green again declined Dr. Blue's recommendation to further investigate the pathology findings, advising that she was feeling better and did not want to have a second surgery. Mrs. Green agreed that she would let Dr. Blue know if her problems returned. Dr. Blue's scribe documented this conversation in the office record as follows: "Dr. Blue will order CT or laparoscope if patient still has trouble with pain and fever. Patient said she is feeling better today but will keep us informed if she has any more problems."

Eventually, Mrs. Green's abdominal complaints resolved. She returned to her normal rhythm of life and did not return to Dr. Blue. That is, until October 7, 2016, when Mrs. Green again developed acute abdominal pain and again returned to the Emergency Department, this time at a different local hospital. There, after examination and imaging, Mrs. Green was again diagnosed with appendicitis. Mrs. Green was dumbfounded by this diagnosis, advising the emergency physician that Dr. Blue removed her appendix two years and eight months ago. Regardless, Mrs. Green was taken back to surgery and was found to have a perforated appendix. Given the extent and impact of the infection, her recovery from the second appendectomy was complicated and prolonged, but, after some time, Mrs. Green fully recovered to her normal state of health.

Mrs. Green filed a lawsuit against Dr. Blue, alleging that he failed to remove her appendix during the first appendectomy. The lawsuit also pled fraudulent concealment and alleged

that Dr. Blue failed to inform Mrs. Green that her appendix had not, in fact, been removed. Mrs. Green claimed that Dr. Blue never discussed the pathology report with her, testifying as such at her deposition. Conversely, Dr. Blue testified in his deposition that he did discuss the pathology findings with Mrs. Green, not once but twice, and that he documented these conversations in the medical record. Dr. Blue explained that his discussion with Mrs. Green about the pathology results is implied by his documentation, arguing that it only makes sense that he would have explained why he was recommending a second surgery in conjunction with his recommendation for more surgery.

Discovery was conducted in the case, and expert witnesses were disclosed by both Mrs. Green and Dr. Blue. The case was being prepared for trial when the parties agreed to participate in a voluntary mediation. After negotiations, the parties reached an agreement to settle the case. While he maintained that he did discuss the pathology report with Mrs. Green, Dr. Blue realized that this was a key issue in the lawsuit, and his supporting documentation on this point was not strong. It can be difficult and somewhat of a gamble to predict how a jury will ultimately decide a "he said-she said" issue. Dr. Blue also recognized that, even though he had standard of care support from expert witnesses, it was going to be a challenge for him to explain to a jury how he performed an appendectomy on Mrs. Green but did not end up removing her appendix. For these reasons, Dr. Blue felt more comfortable resolving the case through a settlement than a trial.

This closed claim demonstrates several important points about documentation:

1. Blue received the surgical pathology report from the hospital in paper form, and the record was included in his office chart for Mrs. Green. However, there was no indication on the report that Dr. Blue actually *received and read* the report before it was filed in the chart. This played into Mrs. Green's version of events that Dr. Blue never discussed the pathology report with her. Perhaps, according to Mrs. Green, Dr. Blue never saw the report before it was filed in the chart? A better approach would have been for Dr. Blue to sign or initial and date the report contemporaneously upon reviewing it and then file it in the chart. Doing so would have supported his assertion that he did receive and review the report.

2. The major weakness in the case was Dr. Blue's failure to document his conversation with Mrs. Green informing her of the findings of the surgical pathology report. No doubt, this was an awkward conversation for Dr. Blue to have with Mrs. Green. Memorializing the conversation in the medical record would have been equally awkward. However, failing to document this conversation did nothing to change the fact that Mrs. Green's appendix had not been removed. Such was the true reality of the situation. Documenting the conversation using clear, precise, straightforward language was all Dr. Blue could do at this point to best manage this unfortunate circumstance. Further, from a legal standpoint, by documenting this conversation, Dr. Blue was also recording Mrs. Green's discovery of the alleged

negligence. This begins the running of the statute of limitations, which is the period of time within which a plaintiff has to file her lawsuit.

3. Another weakness in the case was Dr. Blue's documentation of his discussions with Mrs. Green recommending the second surgery. His documentation did not *clearly* explain what was discussed with the patient and why. This made the medical record open to subsequent interpretation and manipulation, allowing Mrs. Green to take advantage of the imprecise documentation to construct an alternate version of events that better benefited her interests in the lawsuit. The documentation also failed to explicitly describe Mrs. Green's refusals for surgery and why. Anytime a patient refuses to follow the recommended medical advice, **it is imperative that the provider fully and thoroughly document the patient's refusal.** Use clear, precise, straightforward language in the documentation.

4. The last documentation point involves Dr. Blue's use of a scribe. Likely, the scribe's involvement in the documentation explains why the language used in the medical record was not medically specific or precise. Having someone else prepare your documentation can be an efficient time saver; however, still invest the time needed to carefully review the documentation and make any necessary revisions before finalizing and signing the record. A small investment of time by Dr. Blue when the medical record was created would have substantially improved the defensibility of the claim several years later.

Most likely, this lawsuit would not have been filed had Dr. Blue's chart contained clear documentation (1) that he informed Mrs. Green about the pathology results; (2) that he recommended a second surgery in response to the pathology findings; and (3) that, fully informed of this, Mrs. Green decided not to follow Dr. Blue's recommendation to have a second surgery. This closed claim gives a strong illustration of how medical record documentation can end up at the center of a lawsuit. Moreover, this closed claim demonstrates how damaging absent or weak documentation can be to a doctor's ability to defend their care.

So, how does one end up having an appendectomy twice? For Mrs. Green, her appendix was in a retrocecal position, so it was not able to be visualized until her colon was lifted. Additionally, her abdomen was significantly inflamed at the time of her first appendectomy. Finally, Mrs. Green was morbidly obese. These three factors complicated the surgical picture for Dr. Blue, making it difficult for him to accurately determine the location of her appendix. Fortunately for Mrs. Green, she is now definitely appendix-free.

[1] Definition & Facts for Appendicitis,"https://www.niddk.nih.gov/health-information/digestive-diseases/appendicitis/definition-facts

Convenience: Delivering on Patient Experience

By Elizabeth Woodcock, MBA, FACMPE, CPC

CVS and Oak Street. Amazon and One Medical. Walgreens and Village Medical. Dollar General and DocGo On-Demand. The list could go on and on. Brought on by the allure of the size and stability of the health care market, retailers are partnering, acquiring, or infusing cash into health care start-up companies. While most relationships are still in their infancy, there's no doubt that they will soon make their mark. None of these companies want to *replicate* your practice; instead, they'll aim to extract the most profitable services.

Years ago, a physician explained his simple strategy to optimize patient volume without drowning: intersperse the "quickie-sickies" into the appointment template. These quickie-sickies, with higher profitability on a minute-to-minute basis, are exactly what the new entrants into the market want. Combine those with medications and other auxiliary products like ibuprofen and bandages – and you have a nice business strategy.

For years, practice management experts have urged physicians and administrators to focus on patient experience. Providing a great service means that patients will come – and stay, ideally preventing these new entrants from extracting services from the medical practice. However, "experience" is a difficult term to embrace in health care. Declaring – "let's give patients the best experience" - to your staff may not always resonate. By the very nature of the situation, your patients are distressed, perhaps even distraught. Employees may be confused: delivering a great "experience" is tough. However, there are tangible opportunities to enhance certain aspects of the patient's journey that will keep these new competitors at bay:

Focus on convenience. Deliver key aspects of the patient's journey in a more expedient manner; self-scheduling, for example, may be the best (and easiest) opportunity to ease a patient's journey into your practice. With self-scheduling, patients can book appointments 24 hours a day, 7 days a week – that's 168 hours, a remarkable jump from the 40 hours in which our phones are typically answered. Allow booking liberally, then scan through the schedule a day or two before to check for anomalies – and consider a more robust appointment confirmation process to eliminate no-shows. Add an automated waitlist to take advantage of cancellations – and serve to deliver on yet another promise of convenience – to get a sooner appointment without having to jump through hoops. Strive for a *frictionless* process for your patients.

Enhance communication. Today, it's difficult to communicate with us. Most practices still rely on phones and fax machines as the primary platforms for communication. Both methods are antiquated, and often frustrate practice employees as much as they irk patients. Consider novel platforms like bi-directional texting and web chats; embrace in-basket messaging, noting that some prominent health systems – Cleveland Clinic, for example – are charging patients for the service. If coded and billed correctly, many health insurers provide coverage for it.

Do your homework. Spend an hour studying the new healthcare entrants; to expedite your search, here are a few to peruse:

Amazon **Dollar General** **Best Buy**

Keep it simple. Document the strengths and weaknesses of each offering – and then step back to consider the opportunities and threats. While you may not agree with these companies' services and platforms – or perhaps their entire being – rest assured that they have spent considerable time testing their ideas before launching. Maintain an open mind;

it's important to anticipate the changing needs of your patients. Review the results at a staff meeting and gather your team's input. Remind your employees – and yourselves – that taxi companies thought they were insulated from Uber, hotel companies from AirBnb, etc. Competition is not a bad thing; we just need to be prepared for it.

Fill the schedule. Medical practices have the great fortune of customers calling day in and day out; some are new, others are well-established. They have one issue in common: they need you. Amazon – and the other retailers – would love to have this problem; we simply need to figure out how to best *channel* the demand. Consider mapping the framework of your schedule, then allow your team to book the appointments without barriers (including empowering the team to make booking decisions without your permission). If needed, hold a few slots open until the day prior – but an even better strategy is to host an "afternoon sweep" each day. During this five-minute huddle, scan the schedule for the next 2 to 3 days. Look for patients who won't show (they've been admitted to the hospital or called in to say they're feeling fine) – and proactively call the patients who are likely no-shows. (Offer the ones who indicate they wish to cancel, a telemedicine appointment instead – research shows that 50% will take you up on it! Of course, only do so if clinically appropriate.) You may find that you don't need to hold the extra slots, as these efforts will result in having a few on the books to accommodate add-ons.

The past several years have altered patients' expectations for customer service; consider assessing your practice's ability to deliver the experience for which patients hope.

Farewell to the Public Health Emergency

By Elizabeth Woodcock, MBA, FACMPE, CPC

The federal government's declaration of a "public health emergency (PHE)" on January 27 2020 is finally coming to an end. On **May 11, 2023**, the PHE concludes – following a lengthy three-year period combatting COVID-19. While there may be no end in sight to the *disease* that caused the world-wide pandemic, the conclusion of the PHE will impact many medical practices from an administrative perspective. Let's run down the key areas that may affect yours:

- Patients will no longer have access to free over the counter COVID tests, vaccines, and (some) treatments; although some insurers may maintain some coverage, it won't be mandated by the federal government. In addition to overhearing some grumbling, your staff may process referrals for these services based on insurers' imposing them as requirements (for example, a referral may be needed for a COVID test by some insurers). Medicaid programs will continue to cover COVID-19 treatments without cost sharing through September 30, 2024. After that, coverage

and cost sharing may vary by state.

- States have been required to hold their Medicaid rosters through the PHE, halting periodic eligibility redeterminations for more than three years. Further, the government required inclusion for a broad spectrum of uninsured patients. With control returned to the states, many are expected to review and (potentially) purge the recipient lists. Disenrollments will begin as early as April 1, making eligibility verifications essential for your practice during the registration process at scheduling and check-in.
- Perhaps the most significant exception granted during the PHE for medical practices was that of telemedicine; prior to the pandemic, telemedicine was limited to a narrow set of circumstances. Just weeks before telemedicine restrictions were to be reimposed with the end of the PHE, the government passed the Consolidated Appropriations Act of 2023. In essence, the new law replicates the flexibilities for telemedicine that the PHE delivered. Therefore, despite the end of the PHE, many services can still be delivered via telemedicine. The new law only covers Medicare beneficiaries, however, so don't be surprised if some insurers – including Medicaid – place more restrictions on virtual services, to include lowering payment rates.

Hospitals have received a 20% increase in the Medicare payment rate through the hospital inpatient prospective payment system for treating COVID patients; that will be eliminated on May 11. Although this reversal of extra payment won't affect medical practices, you may hear (lots of) grumbling from the hospital execs in your community.

For more information, see the government's post about the PHE's conclusion.

Risk Matters: Treating Family Members

By Jeffrey A. Woods, JD

In general, physicians should not treat themselves, members of their own family, or people with whom they have an intimate relationship. There are specified limited exceptions such as in emergency settings, where there is no other qualified physician available, and for short-term, minor problems. See *AMA Code of Medical Ethics, 1.2.1 Treating Self or Family*. In addition to the AMA, individual state Medical Boards have enacted forms of this ethical prohibition which can vary from state-to-state.

Recently, there has been an uptick in the number of state Board investigations related to physicians treating themselves and family members. Many of these investigations are a result of physicians prescribing Scheduled drugs to themselves, family members, and/or intimate partners but not all of them involve controlled substances. These types of investigations can lead to suspension or loss of license to practice medicine, fines, and

costs.

Physicians should be familiar with the AMA Code related to this subject as well as the requirements of the state in which they practice. SVMIC members can access links to Medical Boards and other state-specific information here.

Gratitude or Gift: The Perils of Physician Gifts to Patients and Referral Sources (Part 1 of 2)

By Mark A. Ison, J.D.

"In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime." U.S. Dept. of Health & Human Services Office of the Inspector General, *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse.*

"The Anti-Kickback Statute prohibits in the health care industry some practices that are common in other business sectors, such as offering gifts to reward past or potential new referrals." *OIG Supplemental Compliance Guidance for Hospitals*, 70 Fed. Reg. at 4861 (Jan. 31, 2005).

Expressing gratitude and appreciation through gift-giving is usually considered a virtue. Giving gifts to clients, customers, or referral sources in most industries is also considered smart business. For physicians and other healthcare providers, however, even the most innocuously intended gifts to or from patients and referral sources can expose them to significant consequences.

While the regulatory landscape governing gifts to or from referral sources and patients is complex and nuanced, from the viewpoint of governmental regulators, complexity is not an excuse for non-compliance. As a result, health care providers should consult with an experienced health care attorney before giving or accepting gifts of more than nominal value to or from patients or referral sources.

However, just because a thorough analysis of the risks raised by gift-giving should involve legal counsel doesn't mean that physicians can't spot potential compliance issues. In fact, health care providers' gut reactions and commonsense approaches are the first lines of defense. To support physicians in their detection of compliance risks before they mature into expensive compliance problems, this article seeks to provide a brief and helpful summary of the laws that may apply, as well as some fundamental considerations to keep in mind when gifts are exchanged between physicians and their patients or referral sources.

The Legal and Regulatory Framework

Reimbursing over $2 trillion every year to healthcare providers for the care and treatment of beneficiaries of Medicare, Medicaid, and other federal health care programs, federal and state governments respond aggressively to what they term "fraud, waste, and abuse." That includes any arrangements that could corrupt medical decision-making and billing, lead to improper referrals or patient steering, and increase program costs.

At the federal level, three primary laws govern the giving or receiving of gifts to or from patients and referral sources:

- The Anti-Kickback Statute ("AKS")
- The Ethics in Patient Referrals Act (the "Stark Law")
- The Civil Monetary Penalties Law ("CMPL")

The Anti-Kickback Statute

The AKS establishes criminal penalties for knowingly and willfully soliciting, offering, giving, or receiving remuneration (including non-monetary gifts) in exchange for referrals for items or services reimbursable under any federal healthcare program, including

Medicare and Medicaid. Referral sources covered by the AKS include (but are not limited to) fellow physicians and providers, groups, patients, staff, and vendors. The Department of Health & Human Services Office of Inspector General ("OIG") has interpreted the AKS as covering any arrangement where even one purpose of the remuneration is to compensate for, or induce, referrals.

Violations of the AKS are felonies punishable by steep fines and imprisonment, constitute automatic violations of the federal False Claims Act ("FCA") (which raises the specter of whistleblower suits, additional fines, and treble damages), and invariably lead to exclusion from participation in federal healthcare programs, including Medicare and Medicaid. While the AKS does not expressly apply to referrals for services reimbursed by private payors, the OIG has warned that offering remuneration even for private-pay referrals may violate the AKS if it otherwise induces federal program business.

Gifts to or from sources of referrals for items or services reimbursable under government health care programs, whether such gifts are in cash or in-kind, or are overt or covert, constitute "remuneration" subject to the AKS. Furthermore, while the AKS contains "safe harbors" that protect many common health care business arrangements from AKS liability, safe harbor protection is unavailable for most gifts. Of note, the OIG has stated that the AKS does not prohibit gifts of "nominal value," but has not defined that term under the AKS. Because the OIG enforces both the AKS and CMPL (discussed below), however, gifts that fit within the parameters of the OIG's CMPL guidance (in particular, the CMPL's $15/$75 limit for non-monetary gifts) likely pose a low risk under the AKS.

The Stark Law

The Stark Law prohibits physicians from referring patients to receive "designated health services" ("DHS") payable by Medicare from entities with which the physician (or an immediate family member of the physician) has a "financial relationship," subject to specific exceptions. In addition, entities receiving referrals prohibited by the Stark Law are not entitled to submit claims for reimbursement of the referred items or services. The Stark Law defines "financial relationship" to include both direct and indirect ownership and investment interests and compensation arrangements.

"DHS" include:

- Clinical laboratory services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs

- Inpatient and outpatient hospital services

The Stark Law is a strict liability statute, meaning that no intent to violate the law, or even to engage in prohibited conduct, is required. Indeed, many Stark Law violations are unintentional. In addition to repayment obligations associated with prohibited claims for reimbursement, Stark Law violations can give rise to severe financial penalties and, in some cases where a violation is committed knowingly or a repayment obligation is not timely satisfied, liability under the FCA.

Any monetary or non-monetary gift between a physician and an entity performing or billing for DHS reimbursable by Medicare potentially creates a “financial relationship” triggering the Stark Law’s prohibition on referrals. Unlike the AKS, however, the Stark Law contains a specific “de minimis” exception for certain non-monetary gifts. Under this exception, entities may give physicians (and their immediate families) non-monetary gifts that do not exceed an aggregate of $489 for calendar year 2023 (the permitted amount is indexed for inflation and changes every year on January 1) per physician, if both the following apply:

- The gift is not determined in any manner that takes into account the volume or value of referrals or other business generated for the entity by the referring physician.
- The gift is not solicited by the physician or physician's practice (including staff) and does not violate the AKS or other state or federal laws.

The Civil Monetary Penalties Law

The Civil Monetary Penalties Law (“CMPL”) prohibits, in relevant part, offering or transferring a gift (or other remuneration) to a Medicare or Medicaid beneficiary (i.e., a patient) if the gifter knows or should know that the gift is likely to influence the beneficiary's choice of a particular provider, practitioner, or supplier of items or services. As its name suggests, violations of the CMPL can result in severe monetary penalties. The prohibition applies both to potential or new patients, as well as to existing patients who may be influenced to continue using a particular provider for future services.

The OIG has interpreted the CMPL's prohibition on patient gifts to allow for inexpensive non-cash gifts with a retail value of no more than $15 individually and no more than $75 in the aggregate annually per patient. Additionally, it may be permissible to offer a "gift" that constitutes an incentive for a beneficiary to obtain certain pre- and post-natal preventative care or that promotes access to care (by improving a beneficiary's ability to obtain items and services payable by Medicare or Medicaid, and not just by rewarding beneficiaries for complying with a particular regimen or plan of care) and poses a low risk of harm to the patient or government programs. Similarly, free health screening services are permitted where (1) they are not conditioned on the use of any items or services from any particular provider, (2) patients are not directed to any particular provider, (3) patients are not offered

any special discounts or follow-up services, and (4) a patient with an abnormal result is advised to see their own health care professional.

State Laws

While federal laws receive the lion's share of attention in the realm of fraud and abuse, providers and their advisors neglect state laws at their peril. Many analogous state laws prohibit or limit kickbacks, self-referrals, fee-splitting, or rebates, and some state laws require the disclosure of financial conflicts of interest. Some of these laws attempt, with varying degrees of success, to mimic federal fraud, waste, and abuse laws. Others go even further than federal laws in restricting the ability of a health care provider to exchange a gift with a referral source or patient. Further, state laws often apply even where referrals or patients involve only services reimbursed by non-governmental payors. In many cases, helpful interpretative guidance is in short supply and must be obtained through direct communication with state officials. In short, state laws are an essential part of the compliance equation, and providers must evaluate them with the same seriousness as federal fraud and abuse laws.

To be continued… *Please see Part 2 of this article in the April Sentinel – where we will cover Ethical Obligations, Takeaways, and Specific Circumstances. If you have questions regarding gifts, SVMIC recommends contacting your corporate attorney or our Medical Practice Services Department at ContactSVMIC@svmic.com or 800.342.2239.*

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