Rebooting Your Leadership Team: A Virtual Interactive Series

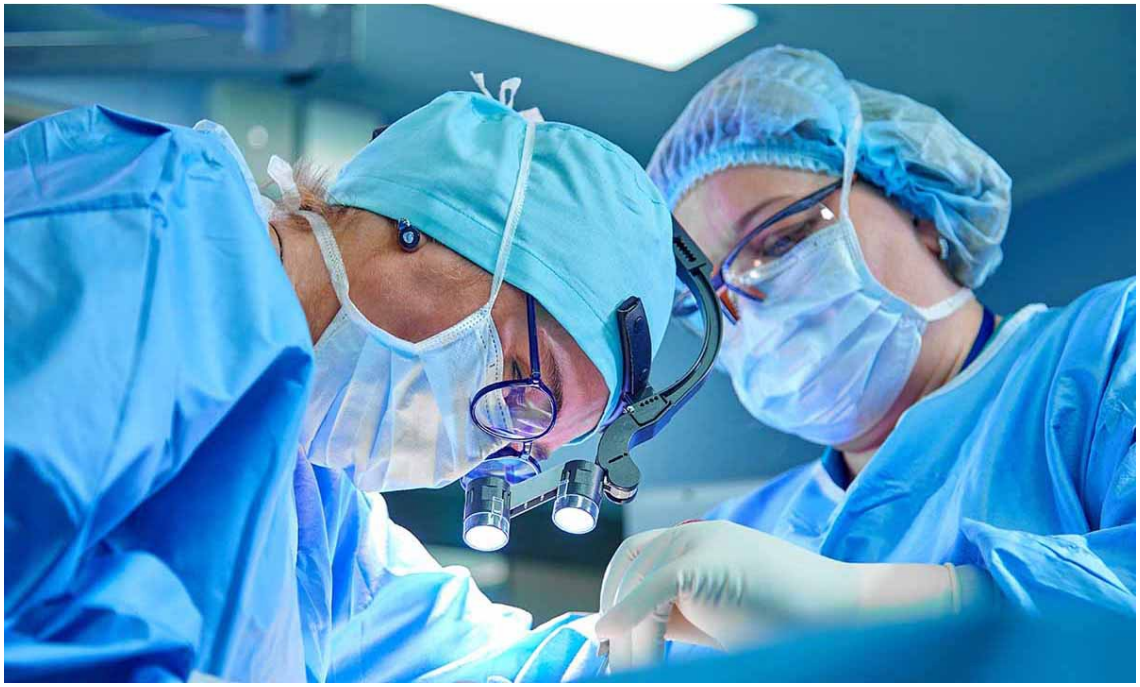
By Stephen A. Dickens, JD, FACMPE

As we look to 2021, it is time to begin assessing operations and developing plans for the new year. While the current environment brings new challenges and uncertainties, some things remain constant. One is the need for leadership and direction within an organization. Successful practices have a defined mission and core values which are reflected in how they treat patients and employees. Not only do these practices have a plan, but employees know where they fit in the plan, the rationale behind it and why it is essential to work together as a team.

In our November workshop series hosted by the Medical Practice Services Department, you will learn strategies for enhancing your own leadership style and walk away with specific techniques to implement within your organization, including how to have difficult conversations. We will address the necessity and methods for setting goals and priorities for the coming year. At the conclusion of the three sessions, you will have developed an action plan specific to your practice.

There is no charge for this virtual interactive workshop, but registration is limited. For more information and registration, click here.

Things Aren't Always As They Appear



By Tim Rector, JD, MBA

There are numerous stories in religious writings with the object lesson of “Things are not always what they appear,” but that lesson is fitting in the study of the sciences, and I submit as well as in the law. Take for example this scientific experiment: Fill a glass with tap water and drop a penny into the glass. Place a penny on the table next to the glass and compare the two. Are the pennies identical in size, or does one penny look bigger? As light enters the water in the glass, the speed at which it is traveling slows down. The rounded shape of the glass and of the water causes the light to bend outwards. As it bends, it extends the image it surrounds outward slightly as well, making the object appear larger. It works as a magnifier and is an illusion. The lesson here is one reason not to immediately trust what you see.

In this story, a female who was 26 years of age at the time of surgery brought a lawsuit in Tennessee, claiming her abdominal and liver problems were caused by two retained clips on the hepatic duct from her laparoscopic cholecystectomy surgery performed 13 years previously. In 2006, the patient brought a lawsuit against the surgeon who performed that surgery in 1993. The paramount question presented in this case is “did the one-year

statute of limitations act as a bar to the plaintiff's claim?" In most cases, there is a one - or two - year statute of limitations, depending on jurisdiction, which begins on the date the health care provider's alleged negligence occurred. However, an injury caused by medical malpractice may not always be apparent at the time it occurs. When this happens, there are some exceptions that may change when the statute of limitations period begins to run. Most notably, the discovery rule can apply when an injury caused by medical malpractice is not discovered at the time the error was committed. If so, the statute of limitations may run from the day the injury is discovered. Tennessee medical malpractice cases are subject to the one-year statute of limitations; however, Tennessee also has a three-year statute of repose which bars patients from filing lawsuits after three years have passed since the date of the incident. Not all states have a statute of repose but instead may have an applicable discovery rule that can extend the statute of limitations period. There are two circumstances that fall within exceptions to the statute of repose: (1) a negligent medical provider commits fraud, concealing their actions so the patient cannot discover malpractice; and (2) a medical tool or instrument is unknowingly left inside a patient. In this Tennessee case, the plaintiff relied upon one of the exceptions to the statute of repose to file a lawsuit 13 years after her gallbladder surgery. Plaintiff's counsel presented facts to give the appearance that the surgeon intentionally or unknowingly failed to remove the clips before concluding the surgery, and the patient first learned that the retained clips were the cause of her injury in 2006. She brought the lawsuit within one year of that discovery.

This surgeon performed an uneventful gallbladder surgery in 1993 on this patient. The patient claimed she did not discover a problem until she developed severe abdominal pain in 2006 and that the cause of her problems was allegedly due to the hepatic clips placed by this surgeon in the 1993 gallbladder surgery. In January 2006, the patient's abdominal pain became severe, and the patient sought care at a university hospital. In August 2006, surgery was performed to remove the surgical clips determined to have been retained in the original 1993 surgery. The patient spent three days in the hospital and was ultimately cleared of any liver disease.

The surgery in 1993 was described as difficult in the operative report and noted that the cystic artery was very close to the right hepatic duct. The two clips were said to be placed on the cystic artery near the right hepatic duct. The defense acknowledged that the two clips were placed on the right hepatic duct in the surgery performed in 1993. The defense further acknowledged the clips were not intended to be placed on the right hepatic duct. However, there was no proof that the plaintiff sought medical attention from 1993 to 1999 for problems related to the clips.

In 1999, the plaintiff had elevated liver enzymes reported as part of a regular annual physical, and she had an ERCP in September 1999. The plaintiff was briefly admitted to the hospital for abdominal pain following the ERCP. The report from the ERCP did not mention or document clips on the right hepatic duct or any occlusion of that anatomy. The patient was subsequently followed by Dr. Smith[1], a gastroenterologist, in 1999 and 2000. On December 20, 1999, Dr. Smith looked at the ERCP and identified the surgical clips on

the right hepatic duct as the medical reason for the elevated alkaline phosphatase. Dr. Smith testified that this information was communicated to the plaintiff in December 1999. Dr. Smith saw the plaintiff again in October 2000, and he recommended no surgical intervention was necessary based on a negative liver biopsy. The patient continued with regular office visits with her primary care physician from 2000 to 2003, reporting a history of right upper quadrant abdominal pain.

By the time the lawsuit was filed in 2006, Dr. Smith had relocated his practice from Tennessee to Iowa. The defense team was able to locate Dr. Smith and obtain a copy of his records related to the treatment of the plaintiff. His records clearly showed the plaintiff was aware in December 1999 that her liver problem was related to the clips on the hepatic duct. The defense team filed a motion for summary judgment arguing the plaintiff knew or had reason to know in December 1999 that the clips were the cause of her elevated liver enzymes which triggered the one-year statute of limitations period within which to file suit; thus, the filing of the suit in 2006 was untimely. The plaintiff's attorney argued that their client did not have sufficient facts communicated to her in 1999 to place her on reasonable notice of a claim, and she did not know of the injurious effects until her surgery in 2006. The plaintiff's counsel used subjective arguments regarding his client's frame of mind in 1999 to minimize the facts of what Dr. Smith told the plaintiff in 1999. The plaintiff took the position she did not have enough information to determine she had a claim at that time. The trial judge denied the motion for summary judgment holding that in order to obtain the benefit of the extension of the normally applicable statute of limitations, the plaintiff's delay in discovering the injury must have been reasonable, and this was a question for the jury to answer.

The case went to trial. The defense team felt confident the jury would find the plaintiff filed her lawsuit too late and would not have to address whether the standard of care was met or whether the alleged negligence caused the injury. Well, how did the jury decide to handle the question of the statute of limitations? Astonishingly, after four hours of deliberations, the jury skipped over the statute of limitations question but found that the surgeon complied with the standard of care. Interviews of some of the jurors after the trial indicated that most of the jurors believed the plaintiff filed her lawsuit too late, but some jurors did not see it that way. However, all the jurors agreed that the surgeon complied with the standard of care so they found in his favor.

As noted by defense experts, there was no foreign body left by mistake in the patient's body. The intent was to place the clips in the patient's body and leave them there permanently. Obviously, the retained clip as a foreign body was a bold theory by the plaintiff which could have been circumvented earlier (and likely prevented the filing of the lawsuit) had the original surgeon advised the patient of the permanent nature of the clips and documented that conversation.

[1] The names and locations in this report have been altered.

Flu Shots in a Pandemic: Alternatives to In-Office Administration So That Patients Feel Safe

By Julie Loomis, RN, JD

With COVID-19 still at the forefront of our nation's health priorities, there is increasing concern about an overlapping flu season. Patients who are already deferring routine and even acute care needs may not be willing to come into the medical office to receive a flu vaccination. Health experts warn that, without optimal management of the flu, healthcare resources could be overwhelmed. This year it may be more important than ever to make the flu vaccine available and strongly encourage your established patients to get vaccinated.

The symptoms of COVID-19 are like those of the flu, including fever, cough, sore throat, body aches and nausea. The annual flu vaccine is an established and generally effective effort to protect patients from the anticipated flu strain. In a time when patients do not feel

safe to come into the office, it's important to consider alternatives outside of the office setting.

To reduce COVID-19 exposure and attain physical distancing, many offices are setting up alternate vaccination clinics for established patients. These clinics may be off-site and set up as a mobile or "drive-up" flu shot clinic, which eliminates the need for patients to get out of their vehicle. Many practices plan to offer outdoor drive-up areas, with vaccination tents like COVID testing sites. A physician or advanced practice provider must be immediately available for urgent issues as well as for patient questions. Other options may include walk-through sites (churches, community centers, and tents).

To assist with this effort and offer general guidance, The Centers for Disease Control has a dedicated webpage entitled, "Guidance for Planning Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations." Best practices for alternate vaccination sites require additional considerations during the COVID-19 pandemic, including physical distancing, personal protective equipment (PPE), and enhanced sanitation efforts. These additional considerations are called out in boxes throughout the CDC guidance. However, because COVID-19 guidance is evolving, infection control guidance for healthcare professionals about coronavirus (COVID-19) should be checked on a regular basis for updated information. Consider signing up for the email updates on the website to stay informed of any changes.

The National Adult and Influenza Immunization Summit also released a "Best practices for vaccination clinics at satellite, temporary or offsite locations" checklist that can be found on the CDC website or here. NOTE that the CDC recommends a 15 minute waiting area after the injection is administered (whether in a vehicle or on foot) to ensure patients do not have an adverse reaction or need care following the vaccination. This checklist also addresses elements that should be a routine part of your documentation with all vaccinations. If the practice intends to administer vaccines to new patients, keep in mind that the administrative requirements of establishing care for a new patient would apply (intake forms, HIPAA, creating a medical record, etc.)

Vaccine consent is not specifically addressed on the checklist. Generally, the theory of implied consent is enough for the flu vaccine. However, it is important to ask patients appropriate screening questions and offer the patient an opportunity to ask questions prior to receiving the vaccine. At a minimum, be sure to document each of the following:

- The information read to the patient
- A copy of the federally required Vaccine Information Sheet (VIS) given to the patient, including edition date and date VIS was provided;
- Information about their visit to the Flu Clinic that includes what to expect and when to call back with contact information
- Confirmation that the patient agreed to proceed with the injection and designated 15-minute waiting period following the injection. Remember to report any clinically significant adverse event to the Vaccine Adverse Event Reporting System (VAERS)

If signed consent is preferred by the practice, to expedite the process, established patients could be asked to print the documents beforehand and bring them to the location where they can be signed. There could be digital consent via a mobile device as well.

With some time and effort directed toward planning for alternative locations for flu vaccinations early in the season, the goal of record-breaking flu vaccinations will be met.

New CPT® Code for COVID-19 Expenses

By Elizabeth Woodcock, MBA, FACMPE, CPC

On September 8, the American Medical Association announced the addition of CPT® 99072 with the express purpose to account for the supplies and clinical staff time required for medical practices to mitigate COVID-19 transmission. Acknowledging the practice expenses related to patient safety during the pandemic, the AMA states that the code represents “supplies, materials, and clinical staff time required for patient symptom checks over the phone and upon arrival, donning and removing personal protective equipment (PPE), and increased sanitation measures to prevent the spread of communicable disease.” The AMA also outlines the code’s coverage of providing instructions on social distancing; surgical masks; and cleaning supplies. 99072 is to be reported once per face-to-face encounter during the Public Health Emergency (which ends October 23); it is only for use in non-facility settings such as physicians’ offices. The use of the code is not dependent on the patient’s diagnosis.

99072 is effective for use immediately, however, getting paid is the tricky issue. The code

was announced prior to the establishment of the code's value, so there was immediate confusion about the amount to charge for 99072. More importantly, the AMA makes it clear that reimbursement (as well as other requirements such as documentation) is up to each payer. Watch for news regarding payment for this new code – and advocate for its coverage.

CPT® Description

99072: "Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease."

For more information about 99072, see https://www.ama-assn.org/system/files/2020-09/cpt-assistant-guide-coronavirus-september-2020.pdf.

For more information about the Public Health Emergency Declaration, which was last renewed on July 23, see https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
