Risk Matters: The Continuing Growth and Persisting Challenges of Remote Healthcare

By Justin Joy, JD, CIPP

Remote healthcare technology continues to be an increasingly valuable tool, especially for delivering care to patients who have mobility or transportation challenges, or who live far away from their provider. According to a 2023 HHS report surveying over a million individuals, 22% of adults in the US reported using telehealth services within the past month.[1] Another survey indicated that, as of the end of 2022, 80% of individuals had received healthcare by telemedicine, an 8% increase from the prior year, with it becoming a preferred modality for prescription management and treating minor illnesses.[2] A 2023 study found that a majority of healthcare systems surveyed were investing in expanding their virtual health and remote monitoring capabilities, as well as their home care service capacity.[3] Additionally, as remote monitoring technology[4] continues to evolve and improve, an increasing amount of care can be delivered to patients remotely. Indicative of

this trend, the American Medical Association introduced five new CPT codes for remote therapeutic monitoring (RTM).[5] Further, CMS recently issued clarifications for remote monitoring services coverage.[6]

Despite the continued growth in utilization by both patients and providers, as well as continued investment in remote healthcare technology, points of friction remain. Licensure restrictions continue to be an area of risk for providers, as most state laws consider care to be provided at the place where the patient is located at the time of the visit (i.e., the originating site). While there are some states with exceptions, providers should assume that a full medical license in the state where the patient is located is required for treating a patient by telemedicine located in another state at the time of the visit. Additionally, many states have specific restrictions on certain prescribing practices and other aspects of delivering care via telemedicine of which providers must be aware. Although professional organizations such as the American Medical Association and the American Telemedicine Association continue to advocate for state licensure efficiency and flexibility to expand the utility and availability of telehealth, many states remain quite restrictive on an out-of-state provider's ability to treat their established patients by telemedicine, even those temporarily located in a state in which the provider is not licensed.[7]

Reimbursement for telemedicine and remotely delivered healthcare services continues to vary by plan and payor. While other variables (such as age and income levels) can influence utilization rates, the 2023 HHS report revealed that patients with Medicare or Medicaid were more likely to use telehealth than those with commercial coverage, while patients without any health insurance were the least likely to use telehealth.[8] Providers and their groups should be familiar with telehealth billing guidelines, including the necessary information to be reported for reimbursement for services provided remotely. These guidelines, many of which were altered during the COVID-19 public health emergency (PHE), continue to evolve. For its part, CMS has extended many PHE telehealth flexibilities, such as the elimination of geographic and modality restrictions, through December 31, 2024.[9]

[1]. U.S. Department of Health and Human Services Office of Health Policy, "Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)" at 3 (April 19, 2023), https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf (the "2023 HHS Report").

[2]. Rock Health and Stanford Center of Digital Health, "Consumer adoption of digital health in 2022: Moving at the speed of trust," https://rockhealth.com/insights/consumer-adoption-of-digital-health-in-2022-moving-at-the-speed-of-trust/.

[3]. PwC, "When the walls come tumbling down: the hospital of the future," https://www.pwc.com/us/en/industries/health-industries/library/healthcare-delivery.html

[4]. These devices should often be differentiated from consumer wearable devices, which were addressed in a recent Risk Matters article.

[5]. American Medical Association, “As remote patient monitoring expands, so does CPT to describe it” (April 15, 2022), https://www.ama-assn.org/practice-management/cpt/remote-patient-monitoring-expands-so-does-cpt-describe-it.

[6]. CMS CY 2024 Payment Policies under the Physician Fee Schedule (Nov. 16, 2023) (PDF pages 178–185), https://public-inspection.federalregister.gov/2023-24184.pdf.

[7]. American Medical Association, “AMA issue brief: Telehealth licensure - Emerging state models of physician licensure flexibility for telehealth” (May 8, 2023) (see AMA perspective and model board rule language on pages 3–4), https://www.ama-assn.org/system/files/issue-brief-telehealth-licensure.pdf; American Telemedicine Association, “Recommendations on Enabling Healthcare Delivery Across State Lines,” https://www.americantelemed.org/policies/atas-recommendations-on-enabling-healthcare-delivery-across-state-lines/.

[8]. 2023 HHS Report at 7.

[9]. U.S. Department of Health and Human Services, “Telehealth policy changes after the COVID-19 public health emergency,” (last updated Dec. 19, 2023); https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency. Additionally, CMS has a guide for providers serving Medicare patients, “Telehealth for Providers: What You Need to Know.”

SVMIC Launches New Compliance Tools for OSHA Officers

By Leslie L. Snider, MS, FACMPE, CHC, RT(R)

Ensuring employee safety is critical in any medical setting, as it not only protects individuals' well-being but also contributes significantly to a practice's overall success and productivity. Prioritizing the safety of employees creates a positive work environment, fostering trust and loyalty among the staff. Safe working conditions reduce the risk of accidents, injuries, and illnesses, leading to lower absenteeism and increased employee morale. A commitment to employee safety also demonstrates the practice's understanding of their ethical responsibility, helps in avoiding legal issues and financial liabilities associated with workplace injuries, and ultimately promotes the overall success and reputation of the practice.

To assist our policyholders in fulfilling their employee safety responsibilities, SVMIC has launched The Compliance Center on our Vantage® policyholder portal. This comprehensive resource includes a complimentary, customizable OSHA Compliance Manual to ensure practices have the tools necessary to implement the policies and

procedures that will help to minimize or eliminate the risks their employees face while on the job. The OSHA Compliance Manual covers OSHA standards important to medical practices, including, but not limited to, Bloodborne Pathogens, Hazard Communication, and Emergency Action Planning. Within the Compliance Center, we have provided over 20 fillable forms and resources, along with 6 online, self-paced OSHA Officer training videos to accompany the manual and assist the practice in their responsibilities related to compliance.

For more information about these OSHA compliance tools, please contact ComplianceCenter@svmic.com. Stay tuned for additional HIPAA resources to be made available in 2025. As always, SVMIC is available to answer any other questions you may have and assist you in your medical practice needs; we can be reached by phone at 800.342.2239 or by email at ContactSVMIC@svmic.com.

Advanced Practice Providers: An Opportunity to Address Lengthy Appointment Waits

By Elizabeth Woodcock, MBA, FACMPE, CPC

Researchers are finally supporting what you already experience every day in your medical practice – there is an overwhelming amount of patient demand. According to a national data repository, visits are up 14% over 2019's pre-pandemic baseline. This fact, in combination with mounting evidence of an impending physician shortage, has medical practices increasingly evaluating the opportunity to integrate or expand the utilization of advanced practice providers (APPs). This category of clinicians includes physician assistants (PA), nurse practitioners (NP), certified nurse midwives (CNM) and certified registered nurse anesthetists (CRNA). As demand for their services has grown, the cost of recruiting, hiring, and retaining APPs has also increased. Therefore, intentionality about their use in your practice is vital. If employing an APP is in your future, these factors may be under consideration:

Ditch 'incident to'? Historically, medical practices used a specific protocol to bill for the services of advanced practice providers. A Medicare term, "incident to", translates into billing for the APP's services under a physician's name/NPI in the outpatient setting. The billing physician is typically the supervising physician or another physician in the same practice, who may not interact with the patient for the encounter. There is an extensive set of requirements to bill 'incident to', and most commercial insurers have adopted this Medicare concept. There are, however, nuances that differ between insurers (including Medicare Administrative Contractors), and the rules are constantly changing. Appropriately complying with current requirements, therefore, requires a heavy lift for the practice, with no room for error. In turn, the practice receives 100% of the physician fee schedule when billing 'incident to'. However, many practices are migrating away from this once-preferred billing method. Why? Insurers are recognizing APPs as billing professionals (with some insurers even agreeing to pay the higher physician rate). With the shift to value-based payments, direct billing by the APP allows insurers to monitor the quality of care the APP provides using their quality indicators. Further, there is evidence that relieving the practice of the burden of the requirements may translate into higher productivity.

Refine the pitch. The words that staff use when referring to APPs are crucial. Consider the patient's perspective during a phone call to schedule an appointment under these two scenarios:

> *Dr. Famous is busy until later this spring, but there is a midlevel available. Her name is Judy, and she can see you next week. Would you like to schedule your appointment with the physician extender?*
>
> *Dr. Famous has appointments available later this spring, however, a member of Dr. Famous' care team has an opening next week if you'd like the team's first available appointment. Judy Garcia is a certified physician assistant, and I can get you in with Ms. Garcia next week. Would you like to schedule your appointment with Judy Garcia?*

Many patients would take advantage of the second scenario, while most (not surprisingly) would refuse the first. There is no industry standard for the script; however, practices are

moving away from the descriptors, “non-physician,” “midlevel,” and “extender,” as they may have a negative connotation for some patients (and providers). Further, references to the clinician as being possessed or owned by a physician are also migrating out of our lexicon. The terms are being replaced by the clinician’s name and credential and/or the collective term, advanced practice provider. (It is important to comply with any Title Transparency laws in your state.) Although references by staff are important, the most important stakeholders for the refined script are the physicians. If you don’t believe that your advanced practice provider is a valuable member of your team, your patients are going to sense that – and avoid seeing them. On the flip side, your encouragement can make a huge difference.

Understand the role. Medical practices hire advanced practice providers for a multitude of reasons. APPs may focus on post-operative visits exclusively, for example. Practices are considering novel ways to deploy advanced practice providers because of the ever-increasing disparity between supply and demand. For example, a neurology practice may employ an APP to manage patients with Parkinson’s and support their caregivers (caregiver training is now billable for select insurances, including Medicare), under the direction of the neurologist. Or the practice may offer same-day/next-day rapid-access appointments for patients, managed by the APP. Other approaches include messaging and/or telemedicine visits, both billable for Medicare and many other insurers. Finally, APPs are increasingly being used for new patient encounters, with the goal of assessing the patient, determining and arranging for diagnostics, and engaging with the patient and family. Importantly, these decisions are impacted by the physicians’ support of the role, as applicable; the professional’s scope of practice; and the relevant state regulations.

Consider this new resource if you’re evaluating the role of APPs in your practice.

Advanced practice providers may not be able to *fully solve* the supply and demand imbalance in your practice, however, they may be able to help. It’s an opportune time to consider the role of an advanced practice provider in your practice.

The Importance of Protocols and Supervision When Utilizing Advanced Practice Providers

By Jamie Wyatt, JD

Given the ever-increasing physician shortage and high demand for appointments, it is common for a patient to receive treatment from an advanced practice provider (APP) when seeking medical care. Appointments with an APP often give a patient the opportunity to be treated sooner for a problem. The continued projection of lower numbers of physicians practicing medicine and its impact on meeting our needs due to population growth and aging is a real concern. [1] According to the Association of Medical Colleges (AAMC), the physician shortage will be up to approximately 86,000 by 2036 [2].

Many physician offices are turning to a more collaborative care approach. While this approach allows a physician to treat a larger patient population, reduce costs, and minimize administration burdens, it is not without inherent risks. When more providers are

involved with care in a collaborative team approach, the risk of liability exposure increases resulting in communication failures, inadequate protocols, and allowing too much autonomy to an APP. Allegations a physician may face in a lawsuit when an APP provides care are often for vicarious liability and negligent supervision. The closed claim review below is an example of the pitfalls that can occur when an APP is given too much autonomy due to minimal supervision and the absence of proper protocols.

This claim began with the treatment of a 22-year-old male who had a history of mental health illness. He presented to the Dr. Strobl's* office with 5-month-old labs showing minimally elevated TSH (Thyroid Stimulating Hormone) of 6.24 (N1 0.30-4.90) and complaints of sleep issues, weight loss, fatigue, and low testosterone symptoms consistent with hypothyroidism. The patient saw Nurse Practitioner Bower.* NP Bower evaluated the patient and noted in the record that he had abnormal thyroid function tests. He documented this based on the patient's old labs and the patient's assertion that he had hypothyroidism. Nurse Practitioner Bower ordered labs, which included a complete thyroid panel, an ultrasound, and thyroid uptake scan. The thyroid evaluation showed a TSH of 1.00 (N1 0.30-3.04), Anti-Thyroid antibodies 29.9 (N1 28-60), Free T4 1.03 (N1 0.58-1.54), Free T3 2.67 (N1 2.30-4.20) all of which were normal despite his discharge diagnosis of hypothyroidism. A follow up appointment was scheduled for 3-4 weeks. When the patient returned for his follow up appointment, NP Bower ordered a thyroid scan and a radioactive iodine uptake test (RAIU) due to "unspecified acquired hypothyroidism", despite a lack of documentation to support this finding. Dr. Strobl signed off on this order. Following this test, there was a report generated from the medical facility that performed the study, but it never made its way into the provider's chart. Instead, the medical chart contained a dictated note from NP Bower stating the test showed it to be "abnormal consistent with Graves Disease". The Thyroid Scan Report results obtained at 4 hours were 12% uptake (NI 5-15%), and 24 hours of 44.5% uptake (NI 10-30%), or a slight increase in uptake at 24 hours suggesting elevated thyroid. Our expert noted that this kind of increase, while consistent with Graves' Disease, is not sufficient for its diagnosis. There were significant red flags that should have caused Dr. Strobl to step in and evaluate. Unfortunately for the patient, Dr. Strobl never saw him. A few weeks later, NP Bower issued an order for I-131 thyroid ablation treatment that was countersigned by Dr. Strobl, who authorized the treatment based on the erroneous diagnosis of Graves' Disease made by the NP. The patient underwent a radioiodine ablation. Post ablation, he was seen multiple times with worsening complaints of palpitations, anxiety, fatigue, overeating, and nausea. When he became truly hypothyroid, NP Bower started thyroid replacement therapy. Following this, the patient never returned and went to a subsequent treater who noted that the patient's thyroid tests were all normal and documented in his notes that "[o]n the basis of this he was diagnosed with Graves' disease and treated with I-131." Suffice it to say, this subsequent treater would not make a good defense witness for NP Bower or Dr. Strobl.

The complaint was filed alleging the patient was wrongfully and negligently diagnosed with Graves' Disease and treated with radioiodine I-131, which caused permanent damage to his thyroid. The plaintiff alleged that the radioiodine ablation caused him to develop complications, including permanent hypothyroidism mandating continuous follow up care

and daily medication to correct low thyroid hormone condition. The plaintiff also alleged that he developed cardiac arrhythmia, cognitive deficits, and other conditions that impacted his ability to continue his education.

There were several weaknesses in the case that were difficult to overcome and led to settlement of the lawsuit. These weaknesses primarily centered around the absence of written policies and protocols outlining the scope of practice and delineating Dr. Strobl's relationship with NP Bower. The depositions supported the plaintiff's theory that there was no meaningful supervision. Plaintiff's IT expert noted that the audit trail revealed that Dr. Strobl devoted 8 seconds to review documentation relating to the initial presentation of the patient. The witness further testified that Dr. Strobl devoted a total of 3 minutes over a span of 7 months to chart review for this patient. Dr. Strobl never saw the patient, nor did he intervene when put on notice that NP Bower was ablating a thyroid. Dr. Strobl did not participate in any of the actual care that led to the final diagnosis of any condition in this case. The plaintiff's attorney argued that a physician's education, knowledge, and expertise must be used to diagnose serious conditions such as Graves' Disease. The plaintiff's attorney argued the purpose of supervising a nurse practitioner was to assure compliance with the standard of care. Further, the plaintiff's attorney made the argument that the physician had no clear boundaries set with NP Bower, which allowed him to provide treatment outside the scope of his expertise. There was no real oversight of NP Bower's work other than the obligatory checking of the box as to the chart review. The medical records failed to support the clinical diagnoses or justify the management recommended and carried out by NP Bower, making defensibility of the case difficult. To add to the defensibility issues, Dr. Strobl testified in his deposition that he never saw the patient or consulted on his labs and scans. When questioned by the Plaintiff's attorney about protocols, it was clear that Dr. Strobl did not know that according to his office protocols, he was required to see the patient on the first visit based on his complaints of thyroid issues. Further, to avert liability, Dr. Strobl stated that NP Bower should have known to come to him to discuss the encounters, but that he had a pattern of acting of his own accord. While this testimony was true based on all accounts, the attempt to deflect liability only increased it because Dr. Strobl acknowledged this dynamic existed and had taken no action to prevent it. Following depositions, Plaintiff's counsel had enough proof to support his claim of no meaningful oversight. The case's posture changed from defending the care to mitigating damages.

Physicians responsible for collaborating with or supervising the care provided by APPs can implement strategies to ensure appropriate oversight and compliance with state board requirements. Below are some major takeaways...

Major takeaways that may assist you in your collaborative efforts and mitigate risk:

1. **Establish Clear Protocols and Guidelines.** Start with the law. To minimize liability risks and maximize patient safety, the physician must establish a system for meaningful and effective collaboration/supervision. The starting place for determining the required level of collaboration/supervision is the applicable state

statute and regulations. Many statutes specify the role of the supervising physician. Some state boards determine the scope of practice of APPs, but others are more flexible. If statutes set forth guidelines, these are often just the minimum requirements for supervision. Evidence-based treatment protocols are typically required to outline the scope of practice, standard of care for the patient population, and include a formulary of approved medications. These clinical protocols should be agreed on, paying attention to symptoms or conditions requiring physician consultation. Set out the consultation method and access to physician consultation. Establish emergency procedures and referral for conditions/treatment outside the scope of APP. Avoid the temptation to delegate beyond the APP's education, knowledge, and competence. Finally, once protocols are established, make sure all parties know them.

2. **Regular Review.** Most states require protocols be reviewed at least every other year. Engage in a regular scope of practice review and medical record review. Most state boards set minimum record review requirements and remote site visits if applicable.
3. **Education and Comprehensive Training.** Provide ongoing education and training to enhance clinical skills, knowledge, and proficiency. Be aware that an APP should have similar practice experience/scope as a physician. This includes any specialized skills, procedures, or training. On the job procedure training is generally not acceptable; some states require board approval prior to training the APP for a new skill or procedure. Have on-going competency validation and a quality assurance plan. The minimum quality assurance standards are often set by the boards.
4. **Effective Communication.** It is important to foster open communication and establish a healthy culture. Be approachable and always ensure availability during the APPs' clinical schedule. Convey your expectation that the APP will contact you or another physician for cases requiring specialized expertise. Provide regular feedback and guidance to foster clinical decision-making. Discuss case concerns and treatment plans. If you see an issue with care, point it out and make it a teachable moment. Most state board rules require time-sensitive physician consultation or review in specific circumstances. Such include: upon a patient request, when controlled substances are prescribed, after an adverse outcome, and when the treatment plan falls outside the protocols.
5. **Documentation.** Your documentation is crucial if there is an allegation of negligent supervision. You should ensure updated documentation of the collaboration/supervision agreement. Document any changes to scope of practice, protocols, and roles. Take the time to discuss documentation requirements and expectations with the APP. Emphasize timely, accurate, and thorough documentation by all parties. Remember that in an audit, investigation, or lawsuit, the metadata is likely discoverable. Be aware of your duties and avoid "signing off" on medical records without the appropriate review.

By following these tips, physicians can better demonstrate diligent collaboration with APPs and mitigate the risk of negligence claims. SVMIC is here to assist you with these and

other risk issues. We have Claims and Risk attorneys available at 1-800-342-2239 or ContactSVMIC@svmic.com.

*All names were changed

1, 2. “New AAMC Report Shows Continuing Projected Physician Shortage.” AAMC, 26 Mar. 2024, www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.

3.Optimizing Advanced Practice Providers in Healthcare.” An MGMA Research and Analysis Report, October 2020, OptimizingAdvancedPracticeProviders_R-A.pdf (mgma.com)