Sometimes, Action Is Required

Mr. Smith was 72, with a long history of various medical issues including coronary artery disease, carotid artery stenosis, chronic obstructive pulmonary disease, and peripheral vascular disease, when he was referred to cardiovascular surgeon, Dr. Jones. The referral to Dr. Jones was by Mr. Smith's primary care physician for evaluation and possible carotid endarterectomy. At his initial visit on May 1, 2010, Dr. Jones determined that surgery was appropriate and ordered a chest X-ray in preparation for surgery. The chest x-ray was performed the following day and interpreted by the radiologist as showing an indistinct opacity in the left mid-lung. The radiologist recommended follow-up with a CT evaluation to confirm or exclude a pulmonary nodule. This report was faxed to Dr. Jones, who initialed the report implying that he had reviewed it. The report was filed in the patient's chart without further action. On May 3, Dr. Jones performed the endarterectomy surgery on Mr. Smith. The surgery went well, and the patient continued to do well through his six-month follow-up office visit with Dr. Jones. The patient was not seen by Dr. Jones thereafter.

In April 2011, Mr. Smith presented to his PCP with complaints of congestion, coughing, and left hip pain. An x-ray and CT of the chest were ordered. These studies indicated that Mr. Smith had lung cancer in the area where the suspicious opacity was previously seen on the May 2010 x-ray. Mr. Smith underwent several months of treatment for metastatic lung cancer and died in early 2012.

A lawsuit was filed by Mr. Smith's estate alleging wrongful death resulting from Dr. Jones' failure to follow-up as recommended by the radiologist in 2010.

Dr. Jones admitted that he saw the report and failed to follow up on the recommendation for further evaluation. There was no credible argument that Dr. Jones had not deviated from the standard of care in this case. On review of the records, an oncologist gave the defense team the opinion that the lung cancer was probably Stage II in May 2010 and was Stage IV in April 2011. It was debatable whether earlier diagnosis would have made a difference in treatment and outcome. Defending the case on the basis that the delay did not change the outcome, and thus there was no injury caused by the error, was the only possible avenue of defense. In every case there are various legal, medical, and practical considerations. In the class of cases involving failure to diagnose cancer, it is well known that for many years the public has been told that early diagnosis equals a better outcome. For many patients this is true. Thus it is very difficult to convince a group of jurors that earlier diagnosis in this specific case would not have made any difference when they have been taught that early diagnosis saves lives. Therefore, successfully defending this case based on causation was going to be difficult.

In his care of this patient, Dr. Jones initialed the chest x-ray report indicating that he had read its content and that he did not believe any further action was warranted. The report,

which indicated further follow-up was needed as to the distinct opacity in the lung, could not be overcome. The plaintiff was able to paint a picture that this finding was simply ignored or not appreciated by Dr. Jones, leaving the consequences of Dr. Jones' failure to fall upon the patient. Findings in radiological reports that suggest further follow-up is needed, require action by the reviewing physician in order to be defensible under the standard of care. Otherwise, convincing a jury that the failure to follow-up did not cause an injury to the patient will be the only chance that the provider has to escape liability. Such cases are challenging for the defendant. In this particular case, Dr. Jones gave his consent to settle, and it was settled.

2017 Risk Education Programs

This year's live Risk Education seminars use real-life experiences and situations as teaching tools for you and your staff. Registration will be open soon!

"Practicing on the Grid" is presented by Justin Joy, JD, CIPP, an attorney with Lewis, Thomason, King, Krieg & Waldrop, P.C. in Memphis, Tennessee, and Jeffrey Woods, JD, the Director of Risk Education at SVMIC. The purpose of this seminar is to discuss the legalities and risks associated with the use of telemedicine, electronic health records (EHR) and patient portals, as well as provide an overview of current cyber liability issues in the medical profession.

"Lessons Learned from Malpractice Claims" is presented by F. Laurens "Larry" Brock, a partner in the Nashville and Chattanooga offices of Adams and Reese. This program examines actual cases and will focus on top risks from the perspective of a medical malpractice trial lawyer including electronic records, patient interaction, informed consent, scope of practice, vicarious liability and documentation.

Either of these programs qualify physician policyholders for a 10% premium credit as well as CME/*AMA Category 1 Credits*™. A complete listing of your 2017 Risk Education offerings will be arriving in your mailboxes and on www.svmic.com soon!

Pain Management Compliance in Tennessee

Physicians and advanced practice providers managing chronic pain should be aware of the changes to the Tennessee Chronic Pain Guidelines which are posted on the licensing board websites. For ease of identifying the changes, a copy of the guidelines is available on SVMIC's website (www.svmic.com). Notable changes include new assessment tools, Non-Opioid therapies appendix and an updated urine drug testing appendix.

Owners of Pain Clinics in Tennessee have new guidelines outlining the requirements of the Medical Director, pain management specialist and clinic owners. Notably, the guidelines state: Medical directors and pain specialists should have a direct and supervisory role in the care of their pain patients. Direct involvement in care includes:

1. If the plan of care is initiated by a nurse practitioner or physician assistant, the medical director or the pain specialist should see the new patient within 30 days of the initial evaluation when opioids are a part of the plan of care. The medical director must be actively involved in ongoing patient care.
2. Medical directors are responsible for establishing and documenting a system of medical oversight that ensures at least an annual face to face visit with the medical director and/or pain specialist for opioid management.

Additionally, there are new "Pain Medicine Clinic Effective Practices" for establishing quality of care which may be used during review or evaluation of a pain clinic's practices. Examples of best practices are outlined in the following categories:

- Individualized interdisciplinary care is provided with clinically appropriate and timely adjustments.
- There is evidence of effective care coordination.
- There is evidence of timely screening for substance use disorder and referral as clinically appropriate.
- Functional outcomes are used as the primary measure of success of treatment.
- There is ongoing emphasis on patient education.
- Naloxone is prescribed for patients at higher risk for overdose or overdose death.
- There is evidence of compliance with legal requirements for licensed pain medicine clinics.

Changes in Federal Alcohol & Drug Abuse Regulations

Providers offering alcohol and drug abuse treatment should also be aware of a recent change in the federal Confidentiality of Alcohol and Drug (A&D) Abuse Patient Records

regulations. There were a number of changes implemented in the final rule with an effective date of February 17, 2017. The changes were intended to update and modernize the nearly 30-year old regulations and to "facilitate information exchange within new health care models while addressing the legitimate privacy concerns of patients seeking treatment for a substance use disorder."

Given the sensitivity of the information contained in these records, the regulations at 42 CFR Part 2 provide more stringent privacy protection than many other health privacy laws, including HIPAA. Regarding the changes to these confidentiality provisions, the new regulations permit a patient to consent to the disclosure of their information using a general designation (e.g., "my healthcare providers") in certain circumstances. This revision is intended accommodate patients being treated in integrated health care systems but patients are not required to permit such categorical disclosures. For patients who have agreed to a general disclosure designation, patients can request a list of entities to whom their information has been disclosed to. The regulations have also been updated and modernized to address both paper and electronic documentation. Providers subject to the 42 CFR Part 2 Rules should remember that, unlike medical records under HIPAA, disclosures of A&D records must be accompanied by a notice regarding the prohibition on re-disclosure of the records. The A&D record rules also have a specific disclosure form content requirement.

MU Payments: Not Too Late for Medicaid

Looking for $63,750 in bonus payments? That's the sum total of the checks you'll receive over a six-year period if you are eligible to participate in the Medicaid Electronic Health Record (EHR) Program. The days of receiving payment boosts for "meaningful use" through Medicare are long gone, but the Medicaid program is still open for business – even for beginners. The program, which is available to Physicians, Dentists, Nurse Practitioners, Certified Nurse Midwives, and select Physician Assistants,^ requires a minimum 30% Medicaid patient volume, or 20% for Pediatricians.

The final year to start the program was 2016, but most states have only just opened their attestation systems for reporting last year's data. If you fit the criteria, you don't even need an EHR. To receive the first bonus check, an eligible provider need only to be in the process of "adopting, implementing or upgrading" (AIU) to an EHR. AIU is defined as adopting (acquiring and installing), implementing (training), or upgrading (expanding functionality with new version, etc.).

Before you commence your state application, you first have to register with the Centers for Medicare & Medicaid Services at the National Level Registry (NLR) CMS Web Site. With the initial year payment of $21,250 – *per provider* – it may be worth your time and energy to explore your options regarding participation particularly when the first-year requirements are minimal.

You don't have time to spare, however. Most states are closing at the end of February or March, and remember that this is your last chance to jump aboard. If you are successful, you'll receive your first year bonus check in eight weeks, with another five payments of $8,500 available through the conclusion of the program in 2022.

Deadlines vary by state; read more about the program requirements at these links:

Tennessee - March 31, 2017

https://www.tn.gov/tenncare/section/electronic-health-record

Arkansas - March 31, 2017

https://www.medicaid.state.ar.us/provider/ehr/ehr.aspx

Georgia - March 31, 2017

https://dch.georgia.gov/medicaid-ehr-incentive-program

Mississippi - April 30, 2017

https://msehrpip.wordpress.com/

Kentucky - February 28, 2017 (registration); March 31, 2017 (attestation)

http://chfs.ky.gov/dms/ehr.htm#register

^Physician assistants who furnish services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

New Coding Opportunity

Chronic Care Management (CCM) services offer the opportunity to receive payment for the non-face-to-face services provided to patients by clinical staff. There are certain requirements for billing CCM, one of which is the establishment of a care plan that provides the foundation of the care provided by staff, often over the telephone.

Many physicians rejected this opportunity altogether, given the time and energy involved in creating the initial care plan. The Centers for Medicare & Medicaid Services (CMS) acknowledged this sentiment with the creation of a new CPT® code for the development and initiation of the patient's care plan, to be used by physicians and advanced practice providers. CMS' rationale? Allow the use of a code for "… the CCM initiating visit to account for the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan."

For use with Medicare patients, G0506 is the "comprehensive assessment of and care planning for patients requiring chronic care management services, including assessment during the provision of a face-to-face service." G0506 is an add-on code, that is listed separately from the primary service. For example, a G0506 can be billed in addition to a 99204. As of January 1, 2017, this CPT® code can be used; however, the code can only be billed once, per patient.

The Afternoon Sweep

Morning huddles offer an exceptional method for preparing for the day; however, it's not uncommon for the results to fall short of one's expectations. Even if your reminder calls went out previously, it's likely that you've had a couple of cancellations that morning. Filling empty slots that are mere minutes away is virtually impossible – and it may prove too difficult to ensure that everything is in place for what always seems like a chaotic morning.

Develop a winning combination by adding an afternoon sweep to your daily routine. Every afternoon, ideally between 3:00 and 4:00 p.m., review tomorrow's appointments. Look for gaps in the schedule, and contact patients before you leave the office for the evening to fill those slots.

Whether during the afternoon sweep or via a new office routine, gap management offers considerable benefit. The revenue associated with that appointment isn't lost, and more patients can be accommodated. Don't leave messages; call until you reach a willing patient. Don't just dial anyone – develop a waitlist with patients' names and contact phone numbers, also incorporating the original appointment date in order to effectively purge the list. Alternatively, call patients scheduled a week or two from now and see if they want to be seen earlier. Finally, maintain a record of patients due for a particular service – like their Medicare Annual Wellness Visit – to contact regarding their interest in being seen.

An afternoon sweep offers a cushion of time to not only address gaps but also review the schedule in order to prepare for the next day. This may include scheduling an interpreter, ensuring that equipment is ready, or tracking down an important test result.

Whether huddling or sweeping, always ask the team for feedback about mistakes. Spend a minute revealing the trials and tribulations of the day – and determine how to learn from these challenges.

REMINDER: If you feel that you are being unfairly penalized for the EHR Incentive Program in 2017, or are being fined in error, file a *reconsideration application*. The Centers for Medicare & Medicaid Services will reconsider the 3% penalty, being applied to all Medicare reimbursement, for the following reasons: new, hospital-based or ineligible professional; PECOS-related issues; hardship; and/or, EHR vendor or MU attestation issue. The form includes a space to provide a brief description. The deadline is February 28, 2017.

Risk Pearls: February 2017

According to the Food and Drug Administration (FDA), it regulates one trillion dollars' worth of products each year or approximately 20 cents on every dollar spent in the U.S. When there is a serious problem with a product, the FDA would like to alert you immediately. The alerts contain actionable information that may impact both treatment and diagnostic choices for clinicians and patients.

Did you know that by signing up for the FDA's Safety Information and Adverse Event Reporting Program, MedWatch, you can report problems that you have had with drugs and other medical products and you can receive safety alerts as soon as they appear on the web site? MedWatch offers an online voluntary reporting form for both clinician and consumer reporting. It also helps you stay informed about the medical products you use, prescribe and administer by sending safety alerts to your inbox. To subscribe, just visit http://www.fda.gov/Safety/MedWatch and sign up.

An Analysis of Urology Closed Claims

By Shelly Weatherly, JD, *Vice President, Risk Education and Evaluation Services, SVMIC*

A review of SVMIC Urology claims from 2009 – 2015, where there was a paid loss on behalf of an insured, reveals that failure to timely diagnose and improper performance of a procedure were the most common noted misadventures. Most often, the diagnostic errors were not the result of lack of knowledge, skill or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of inadequate documentation, communication breakdowns and poorly designed or ineffective systems.

DOCUMENTATION ISSUES: The importance of maintaining a well-documented medical record, from both a patient care and a risk management standpoint, cannot be overstated. As the graph above illustrates, documentation issues were a factor in 53% of claims paid in Urology. Of those, 75% involved inadequate documentation, which can have a negative impact on the defensibility of the care provided to a patient. The cases reviewed involved:

- Failure to document abdominal exam findings in a patient experiencing post-op complications related to a perforated ureter
- No documented rationale for using an unconventional surgical approach
- No documentation supporting proper identification of landmarks prior to stapling followed by inadvertent transection of the inferior vena cava
- Failure to document telephone exchanges with the emergency physician and other hospital personnel
- Lack of documentation of specific risks and benefits of the procedure in a case complicated by a bladder perforation

EHR documentation issues were also present in the reviewed cases. In one case, the physician, over the course of several office visits, incorrectly carried over erroneous documentation suggesting a positive study for an enlarging renal mass, which was the basis for a radical nephrectomy. The post-op pathology report revealed no such cancer. During the deposition, the physician admitted to the documentation errors that were the result of the “copy and paste” function of the EHR system. While the physician’s failure to review the study prior to taking the patient into surgery was difficult to defend, the documentation errors called the entire record, as well as the physician’s credibility, into question.

COMMUNICATION ISSUES: Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient's perception of the quality of care. Communication breakdowns occurred in 47% of the reviewed claims, and the majority of these involved physician-to-patient situations. Examples include:

- Failure to communicate the detrimental effects of smoking to patients undergoing surgery for tumor removal and who subsequently experienced post-op infection and delayed healing
- Failure to clearly communicate the need for follow-up, which resulted in a delay of stent removal and associated infection
- Failure to discuss the risks of infection and bleeding to patients who subsequently developed these known complications following urologic surgery

SYSTEMS ISSUES: Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanism alone. Systems failures were an issue in 42% of the analyzed claims. Failure to track and act on test results and missed appointments were a common theme.

In one case, a patient presented to the ED with flank pain, nausea and vomiting. The CT scan was originally read as normal by the emergency physician who referred the patient to a urologist for admission. Thereafter, a radiologist over read the CT scan and found a 2x3 cm kidney lesion, which he reported to the emergency physician. The admitting urologist was unaware of this information. He noted in his admission history & physical that the CT scan revealed "no obstruction or stone" and listed the diagnosis as "patient passing a kidney stone". The patient was discharged, never having received information about the abnormal CT scan. Two years later, he underwent a radical nephrectomy for renal cancer.

Another example involved a patient who underwent a cystourethroscopy for complaints of hematuria. Urine cytology was collected which revealed malignant cells. However, the report was not transmitted to the office, nor did the lab call the office to report the critical finding. There was no internal tracking in place to alert the physician of the missing test result. A return visit in six months was scheduled, but the patient failed to keep his appointment. Again, the office had no system to follow-up on missed appointments. Nearly a year later, the patient self-referred to another urologist who diagnosed bladder cancer with brain metastasis.

Also observed in the cases reviewed were wrong site procedures. One case involved a urologist removing the wrong kidney. Instead of reviewing the CT films prior to the nephrectomy, the surgeon relied on the radiology report that incorrectly cited the lesion on the right kidney instead of the left. Another case involved a wrong side ureteroscopy with stent placement. A review of the events revealed that there was no time out, the site had not been marked, and the wrong CT scan was on the screen.

LESSONS LEARNED:

- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief complaint or purpose for the

visit; all relevant positive and negative clinical findings; your diagnosis or medical impression; the decision-making process for the clearly defined treatment plan; and all relevant instructions and information given to the patient regarding such treatment plan.

- Document all telephone communication with patients and with other providers, including evening and weekend phone calls.
- If using an EHR, review and correct all documentation that may have auto-populated or been carried over from a previous visit to ensure it is an accurate reflection of the current office visit assessment.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, alternatives, and expected outcome. Be careful not to educate above a patient's comprehension level. Be sure the details of all discussions with patients are documented in office records rather than relying on hospital consent forms, which are not procedure-specific and may not capture all details of a conversation.
- Communicate and document follow up instructions, warnings and relevant discharge information to patients. Be sure to convey such information in terms clearly understandable to non-medically trained individuals.
- In order to ensure proper follow-up for patients who require a return office visit, schedule such patients before they leave the office or the hospital and provide a reminder card with date and time.
- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it's important enough to track and personally review.
- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up.
- Implement a tracking system for patients who miss or cancel scheduled appointments so that appropriate efforts are made to contact the patient and re-schedule the appointment in situations where the patient may suffer if treatment is delayed or where the treatment or medication must be monitored closely.
- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected timeframe.
- If using a tasking system for interoffice communication, be sure to have a surrogate reviewer assigned to open task boxes and review messages for anyone not in the office.
- Educate staff to communicate "critical values" verbally rather than relying on tasking.
- Personally review all diagnostic images as well as radiology reports.
- Review results for all tests ordered preoperatively to ensure that any abnormalities receive proper follow-up.
- Use the Joint Commission's protocol designed to prevent wrong patient/site/procedure surgeries by verifying patient identification, marking the surgical site appropriately with the patient/representative prior to surgery, and perform a timeout to review relevant aspects of the procedure with the surgical team and complete the verification process.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.