Audio-Video Recording of Patient Visits

Everyone has a pocket-sized, easy-to-use audio/video recording device – a cell phone. Just as people record more and more of life's events, many now record conversations with their physicians and other healthcare providers. These recordings can be performed either with permission or surreptitiously. For physicians, there's a good chance at least one of your last 10 patients recorded their visit, with or without your permission, according to research from the Dartmouth Institute for Health Policy and Clinical Practice. In a survey of 128 patients in Britain, researchers found that 15 percent acknowledged secretly recording their encounter. It is safe to say that if you have not yet had this issue present itself in your practice, you will at some point in the near future.

In a well-publicized case from Virginia in 2015, a jury awarded a patient $500,000 because an anesthesiologist and others mocked him during a colonoscopy while sedated. The man had left his cell phone on and in his pocket during the outpatient procedure. Upon waking, the patient listened to the recording and heard members of the medical team making derogatory and unfounded remarks joking that they suspected he had syphilis, Ebola, and tuberculosis. The anesthesiologist and gastroenterologist were recorded disparaging the man and other patients for what they described as bad attitudes.

In 2016, a Texas patient hid a tiny recording device the size of a USB drive in her hair during surgery for the stated reason that she just had a bad feeling about her surgeon and wanted a record of the events in the OR for her family in the event something went wrong. During the abdominal surgery, members of the medical team are heard joking in an offensive manner about the patient's belly button. The anesthesiologist called her a "retard" and the surgeon stated he felt sorry for her husband and referred to the patient as "Precious" which she alleged was a racial slur.

These cases may be extreme examples, but they are important reminders of the need to act in a professional manner at all times regardless of your location and regardless of whether or not you think a patient or family member can hear you. In this day and age, it is safe to assume that you are always being recorded and act accordingly. A good rule of thumb is that if it is not something you would say to the patient directly or to a jury in court, it is not something you should be saying in private or when you think you are in a private setting.

All of this leads to the question: Should patients be able to record their encounters with their healthcare providers? The question raises legal, ethical, and practical considerations. Audio/video recording of healthcare encounters requires balancing potential privacy and

liability risks with the potential benefits of improved patient recollection of instructions and treatment adherence. This often pits the patient's interests against those of the provider.

The laws that provide the primary legal framework regarding recording practices are wiretapping and eavesdropping statutes as well as privacy regulations. State laws differ on whether all parties must consent to the recording. In "all-party" jurisdictions, covert recordings by either the patient or the healthcare provider are illegal since everyone being recorded must consent to be recorded. If a recording is obtained illegally, it should not be admissible in court in a malpractice lawsuit. There are currently 11 all-party jurisdictions: California, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania and Washington.

The majority of jurisdictions in the United States are "one-party" jurisdictions. At this time, 39 of the 50 states and the District of Columbia use the one-party consent rule including Tennessee, Arkansas, Kentucky, Mississippi, Alabama, Georgia and Virginia. One-party jurisdictions require that only one party to a conversation must consent to being recorded to be legal. This means that a patient (or family member, if present) can secretly record the healthcare provider, and, because it is legal, the recording would most likely be admissible in court.

HIPAA and privacy regulations do not prevent a patient from recording their own healthcare encounters. These laws and regulations are designed to protect the patient's health information from accidental or intentional disclosure by healthcare providers and related entities. These regulations do not, however, prohibit patients from disclosing their own protected health information. If the patient creates (records) and possesses a sole copy of a recording, the patient can do nearly anything he or she wants with the information so long as it does not violate another party's privacy rights. If the patient makes a surreptitious recording and posts it online to YouTube, for example, and it can be established that it was disclosed by the patient, the healthcare provider probably has no exposure for HIPAA or privacy law violations. But, that does not mean that there are no consequences to the provider whose reputation may have been maligned. Recently, clinical encounters have been shared on social media much to the embarrassment of the provider.

On the other hand, if a physician records a conversation with a patient or videos a surgery, HIPAA and privacy laws require that the recording must be protected in the same manner as any other PHI. If the physician in that scenario fails to obtain the patient's permission, although not illegal in a one-party state, he or she may have committed an ethical violation that could result in an investigation by a state medical board.

What are the pros and cons of permitting the patient to record healthcare encounters from the practitioner's perspective? The primary benefit often cited is patient comprehension. Patients do not always understand or recall all the information provided during visits. This is especially true if they are receiving distressing news, suffering from an infirmity or are elderly. Most studies show that as much as 80% of the medical information provided to patients is forgotten immediately and half of the information that is remembered is incorrect. Recordings could potentially improve accuracy, adherence, and personal

engagement by allowing the patient or family members and caregivers the opportunity to review the conversation at a later time. Providers who know they are being recorded tend to slow down and choose their words more carefully. This could prove not only beneficial to the patient for better understanding, but to the provider in the event that a claim or lawsuit is asserted.

There are numerous drawbacks to allowing patients to record encounters with their providers. The process could undermine the trust between the provider and the patient. It might inhibit the free flow of information as the patient might be less likely to discuss sensitive information or admit to certain problems (i.e. drug or alcohol use or sexual activity), if the session is being recorded. Further, the recording devices could be disruptive and intimidating causing the provider to practice “defensive medicine.” Fear of litigation, loss of privacy and the threat of publication on social media are valid concerns for the provider. Unlike the EHR, electronic recordings can be altered or manipulated creating an inaccurate impression of the provider or the discussion. The provider does not typically retain a copy of the recording which places him or her at a disadvantage.

Balancing these competing interests, patient advocates, medical ethicists, and authors of professional journal articles have recently recommended that patients be permitted to record encounters with their healthcare providers. Most recognize the move toward transparency in medicine and the ubiquity of smartphones as reasons. Some healthcare providers, primarily in the western United States, are not only permitting recordings, but are furnishing a tablet or recording device for the patient to use. These “pioneers” are preliminarily reporting that patient understanding of medical information has improved while the number of claims has lessened. Many opine that in the future, all healthcare encounters will be recorded.

While this may ultimately prove true for the future, most professional liability insurers and defense attorneys do not currently recommend that patients be encouraged to record their visit. It is a complicated issue with risks and benefits, privacy concerns, technical concerns dealing with how to preserve and re-produce recordings, legal concerns, etc. There is no one size fits all solution.

As stated earlier, it is not illegal to secretly record the visit in a one-party state. Since patients may make surreptitious recordings, a medical practice may want to place a notice sign stating, “Audio or video recordings of any type are prohibited on the premises,” in prominent locations such as the waiting area, exam room and on the practice’s website. In addition, it is recommended that language prohibiting recordings be included in the conditions of treatment paperwork signed by the patient at the outset. The legal sufficiency of these notices will be unknown until tested in court, but they could serve as a deterrent and may provide defense counsel with the basis for an argument to exclude surreptitious recordings which, absent such notices, would not If a patient requests permission to record the visit encourage him or her instead to take notes, have a family member present, or review a pamphlet or other literature you provide. All of this needs to be documented in the medical record.

For providers who choose to be “pioneers” and permit recordings, it is recommended that parameters be set by the provider so that the entire encounter is not recorded. Only the discharge or follow-up instructions should be recorded, not the exam. The portion of the encounter that is allowed to be recorded should be consistent with the provider’s notes and, the provider should retain a copy of the to policies and procedures established by the practice).

Due to the complexity of this subject and the potential ramifications, medical practices should seek advice of corporate counsel when establishing a policy on the recording of patient encounters. The decision has legal consequences and may generate strong feelings that will likely vary from provider to provider and certainly from practice to practice. It should be thoroughly vetted before adopted.

Through the Retrospectroscope: When Connecting the Dots to Diagnosis Comes Too Late

Most of the time, diagnosing a patient's medical problem is a straightforward process. The patient's symptoms are recognizable, and the solution becomes clear to the clinician after formulating a list of differential diagnoses. On rare occasions, a clinician will encounter a confounding constellation of symptoms that do not correspond with any known diagnosis. Faced with this issue, the clinician easily recognizes that the patient needs to be referred elsewhere for further investigation.

Presenting the greater challenge for the clinician, however, is the patient who, at the time of the encounter, presents with non-specific symptoms or symptoms commonly seen in multiple medical conditions. The clinician makes his/her determination of the underlying problem and treats the patient consistent with the presumed diagnosis. Meanwhile, the patient's actual medical issue (often a more unusual or less likely condition) is allowed to progress unchecked. It is not until the patient experiences a bad outcome because of his untreated condition that the real medical problem is diagnosed. Knowing the outcome, however, and viewing the earlier encounters in hindsight, the clinician may then recognize hints of the true diagnosis that were present all along but simply were not appreciated at the time of the care. This is the problem of the "retrospectroscope."

A retrospectroscope is a colloquial term used in the context of medical malpractice litigation. The McGraw-Hill Concise Dictionary of Modern Medicine defines "retrospectroscope" as "the resolution of diagnostic dilemmas if viewed in hindsight."[1] It is through the lens of hindsight that claimants, lawyers, experts, and juries view the medical care rendered to the patient. Retrospectroscope cases can be very dangerous, particularly if the patient's outcome was significant or tragic, because it can be challenging to explain how the clinician failed to recognize what was actually happening with the patient. When everyone knows the ending, that knowledge, that hindsight bias, that retrospectroscope, colors everything that happened before.

Such was the unfortunate case for Michael Jones[2], a twenty-three year old male patient who first presented to family practice physician Dr. Jane Greene on June 13, 2016 complaining of ankle pain for three days. Mr. Jones reported that he was unaware of any injury to his ankle. Dr. Greene noted swelling and bruising of the ankle. Dr. Greene diagnosed Mr. Jones with an acute ankle sprain and prescribed an anti-inflammatory.

Michael Jones returned to Dr. Greene for a second time on June 27, 2016. At this visit, he complained of continued right ankle pain, present now for three weeks. Dr. Greene took an x-ray of the patient's ankle, which was negative for fracture. She instructed the patient to continue taking the anti-inflammatory medication and treat the ankle with rest, ice, elevation, and wrapping. Dr. Greene's diagnosis at this visit was right ankle sprain.

Michael Jones returned again to Dr. Greene on July 25, 2016. At this third visit, Mr. Jones complained of constant bilateral swelling and pain in his calves, ankles, and feet. For the first time, he advised Dr. Greene that he suffered from "mild" and "random" stomach symptoms for the past five years, including diffuse abdominal pain, vomiting, and weight loss. Dr. Greene documented that the ongoing stomach issue "sounds like IBS." As for the lower extremity complaints, she ordered a Doppler ultrasound, which was negative for DVT. Various lab work was also ordered, including CBC and CMP. The CBC was performed in Dr. Greene's office laboratory. The CMP was sent to an outside lab for processing. Mr. Jones' CMP results were returned to Dr. Greene's office the following day, reporting a very low albumin level.

No action was taken by Dr. Greene to follow-up on the July 25, 2016 CMP results. In fact, Michael Jones was lost to follow-up for almost seven months until February 20, 2017, when he returned to Dr. Greene complaining of diffuse and sharp abdominal pain, continued ankle swelling, joint pain, fatigue, and excessive thirst. Mr. Jones reported that he did well initially on his iron supplement for his anemia (this was not prescribed or recommended by Dr. Greene, suggesting that the patient had seen an unknown medical provider during this seven-month interim), and even experienced a little weight gain before losing weight again. Dr. Greene ordered and performed a repeat CBC in her office, which showed low hematocrit and hemoglobin. Dr. Greene did not order another CMP lab. Furthermore, based on her documentation for this visit, it appears that she did not even recognize or address the July 25, 2016 low albumin level. Instead, Dr. Greene diagnosed unspecified anemia, unspecified joint pain, and unspecified abdominal pain. She recognized the need to rule out multiple serious conditions, including both Crohn's disease and ulcerative colitis. However, her note is completely devoid of any documentation about how she intended to further investigate these possibilities or what treatment plan she recommended to address the patient's ongoing problems.

Regardless, Michael Jones returned to see Dr. Greene only two days later, on February 22, 2017. His appointment followed a phone call earlier in the day from his girlfriend reporting that Mr. Jones passed out at work and inquiring whether she should take him to the Emergency Room or just bring him to the office. Dr. Greene recommended that Mr. Jones come to the office for evaluation. Upon presentation, Mr. Jones complained of mild abdominal pain and acute dizziness. Dr. Greene's diagnosis remained unspecified abdominal pain. She prescribed the patient a Medrol dose pack. In her office note, Dr. Greene recognized the need to do further work-up "soon," but there was no documentation of what work-up was recommended or planned.

Only hours after leaving Dr. Greene's office, Michael Jones experienced a sudden cardiac arrest at home. His girlfriend was with him at the time of his arrest and called 911. The paramedics were able to resuscitate Mr. Jones, but not before he experienced a debilitating anoxic brain injury which left him unable to care for himself or live independently. Mr. Jones was ultimately diagnosed with pancolitis, ulcerative colitis of his entire colon, which had progressed so severely as to render him profoundly hypokalemic, thus causing the cardiac arrest. A lawsuit was filed on behalf of Mr. Jones, and the claim was ultimately settled for a significant amount.

In retrospect, Michael Jones exhibited symptoms of ulcerative colitis beginning with his first appointment with Dr. Greene, specifically, the atraumatic ankle injury. By his third appointment with Dr. Greene, the patient's low albumin level and lower extremity swelling and joint pain were additional symptoms of his undiagnosed and progressing inflammatory bowel disease. Likely, at the time of each individual office visit, Dr. Greene was reassured by Mr. Jones' otherwise young and healthy presentation, and the complaints, when assessed in isolation at the time of each individual office visit, did not cause Dr. Greene to suspect ulcerative colitis. However, when the visits are viewed back-to-back, knowing Mr. Jones' ultimate diagnosis and tragic outcome, the retrospectroscope makes one question how this family practitioner missed the diagnosis.

So, what can be learned from Dr. Greene's failure to connect the dots to Mr. Jones' diagnosis of ulcerative colitis? How can this case help clinicians recognize the "zebra" who may be sitting in your exam room?

1. Be attentive to the patient's complaints and presentation during the encounter.

2. Be thorough when writing the record for the encounter, including your presumptive diagnosis and any treatment and/or follow-up plans. If the patient refuses the care you have recommended, document the refusal, including any reason the patient gives for refusing the recommended care.

3. For those patients returning repeatedly with ongoing or worsening symptoms, dig deeper into the situation, or consider referring the patient for a second opinion or to the relevant specialist.

4. Implement and utilize a reminder system to follow up on outstanding lab results, test results, imaging studies etc., then act appropriately on those results once received.

5. Implement and utilize a reminder system for patients, too, who are in need of follow-up, and have your staff contact them to schedule a return visit should they fail to follow-up on their own. If the patient refuses to schedule the recommended follow-up appointment, again document the refusal, including any reason the patient gives for refusing to make the appointment. Also, ask your staff to notify you of and document those instances when the patient makes but fails to keep appointments.

6. Seek out records, information, etc. for relevant care rendered by other providers whom the patient identifies.

7. Take the time to perform a more comprehensive review of your chart for the patient. This allows you to look back over the recent appointments, viewing the patient's complaints globally over time. This is also another opportunity to look for prior test results or recommended treatment and see if any follow-up is indicated or has been scheduled but not

[1] ("Retrospectroscope." McGraw-Hill Concise Dictionary of Modern Medicine. 2002. The McGraw-Hill Companies, Inc.)

[2] The names have been changed to protect patient and physician privacy.

Physician Burnout: Prevention and Treatment

Editor's Note: This is part three in our four-part series on physician burnout. Part I was published in the January 2018 edition of The SVMIC Sentinel and part II was published in the April 2018 edition. Part four in our series will be published in our October edition.

On June 9 of this year, the *Wall Street Journal* published an article titled “Hospitals Address Widespread Doctor Burnout.” It was not alone – Physician Burnout Syndrome has been featured above the fold in many major national newspapers since we began this article series in the *Sentinel* in late 2017. The national attention is appropriate.

Escalating physician suicide rates have also received widespread attention. Symon Productions, an independent movie company, released the documentary *Do No Harm* in March 2018. The movie is about the impact completed suicides of medical students and residents have, not only on their families but on their patients as well. It exposes our “sick healthcare system that not only drives our brilliant young doctors to take their own lives but puts patients’ lives at risk, too.” Physician health has not only become a national topic of discussion, but is also a national concern because sick and burned-out physicians make mistakes that can harm patients, whereas healthy doctors provide better healthcare. That is not just a bumper sticker slogan; there is ample evidence to validate that statement.

In Part I of this series we were introduced to Dr. W. who completed suicide, leaving a trail of burnout symptoms and a wake of sorrow. We saw what burnout is and how it negatively impacts physicians and their patients. In Part II we took a closer look at the drivers and factors of burnout. In this segment, Part III, we will explore another case presentation and talk about prevention and treatment options for Physician Burnout Syndrome at the clinician level.

The Case of Dr. H

Dr. H. is a mid-career internist. She is one of a four-physician Internal Medicine group in a large West Tennessee town. She was raised close to the town where she now lives and has no desire or plans to leave. Her parents still live nearby and are completely independent. Dr. H.’s husband gave up his career as a journalist to become the manager of her practice, as their last three office managers were incompetent and disorganized. Her husband has a history of trying to rescue Dr. H. when she is “stressed,” which only adds to her stress. Dr. H. has three high-school-aged children. She hasn’t been to her children’s ball games, recitals, or school events except an occasional weekend birthday party. The family joke is that she almost missed her children’s births.

Dr. H. leaves for her office around 6:30 am, explaining that she can “get a lot done before the doors open.” From 6:30am to 8:00am she goes over patient emails and messages; she is not reimbursed for this but views it as an important aspect of clinical care because it “helps patients.” Office hours are from 8:00am to 5:00pm with one hour for lunch – a built-in buffer to keep her from being too late in the afternoon. However, she never uses the hour for lunch because patient visits encroach on that time. Similarly, her day rarely ends at 5:00pm – the last patient usually doesn’t leave the office until around 7:00pm. Dr. H. then goes home exhausted. Her husband and children have usually finished dinner by the time she gets home. Her pajama time is spent charting, as she seldom has time to close out charts during the day. Dr. H.’s group utilizes a very efficient Electronic Health Record (EHR), which allows her to chart from any location. However, to avoid simply copying/pasting and having each visit report look like the last, she spends many hours each night capturing and recording the subjective flavor of the day’s office visits in each note.

Dr. H’s story is exhausting. She could not find a way off the devastating treadmill that she enthusiastically got on in residency. Like many physicians, Dr. H. needed help to make changes to the hopeless agony that became her life. Disguised as a virus, that help eventually came. Despite receiving a flu vaccine, she became ill with type B influenza. It took a high fever, chills, rigors, and cognitive clouding for Dr. H. to take time off. Her own primary care doctor, an office partner, sent her home.

Caused by a high fever, viral load, or just plain lucidity, on the fourth day of sick leave Dr. H. had a moment of clarity. She told her husband that evening that she had to make changes that may include changing careers – otherwise, she feared she would soon be dead. Her husband gave her the number of the Tennessee Medical Foundation Physician’s Health Program (TMF-PHP). She called the next day.

Dr. H. had classic symptoms of Physician Burnout Syndrome. Her practice was no longer meaningful or fulfilling. She was emotionally exhausted and received no sense of personal accomplishment from work. She treated her patients as objects and was disengaged. She also felt like a stranger to her husband and children. On closer examination, she had developed intermittent bouts of depression and thoughts that her family would be better off if she were dead.

After a few weeks to recover and implementing strict work boundaries regarding time and clinical load, mandatory vacation, and continued therapy to address perfectionism, Dr. H. is a much happier and better physician. Her husband addressed his codependence and rescue fantasy as well. These changes were very painful and difficult but considered worth the effort by all involved.

Drivers of PBS

Although physicians are a very visible component of healthcare, they are not the primary drivers of Physician Burnout Syndrome (PBS). The organizational components of medicine that have control over and limit the autonomy of the individual physician practice are the

major drivers of PBS. Those drivers include the federal and state governments, hospitals and institutions, and the C-suite executives of physician practices. Reducing PBS is the responsibility of physicians working together with those organizational components.

Drs. Shanafelt and Noseworthy go into detail discussing the "Nine Organizational Strategies to Promote Engagement and Reduce Burnout" in their 2016 article.[1] We will explore the strategies that are more physician-based, including "Promoting Flexibility and Work-Life Integration, Resilience and Self Care," and look at Mindfulness-Based Stress Reduction in more detail as a treatment for PBS.

Flexibility

Almost half of all physicians work more than 60 hours per week, neglecting their own personal and family needs. It's estimated that almost half of that time is devoted to non-clinical activity. Work-Life Integration provides opportunities for meeting family and personal needs. Creating flexibility in physician scheduling is one option that provides the physician with an element of control. Scheduling work days that begin or end earlier or later allows time to meet personal or family responsibilities. This can easily be accommodated in an equitable manner without a decrease in total work hours. Other industries have been utilizing flexible hours with good results and without the scheduling chaos that office managers often predict. Flexible hours may seem unworkable in the single physician office; however, flexible hours can be utilized by planning and blocking needed time off for family or personal obligations. A multiple physician or provider office allows for increased flexibility in scheduling. The physician and scheduler need to work together to accomplish this task.

Another viable option is to allow physicians to schedule reduced hours with a commensurate reduction in reimbursement. This can be especially appealing to double income families so at least one parent is available for after-school functions or activities. Missing a child's game, graduation, or school play can be anything from a faux pas to an unforgivable act, whereas attending a child's event will provide great satisfaction to both parent and child. Flexible scheduling and compensation can be used to promote a healthy balance of family, work, and personal time. The concept of Work-Life Integration promotes a healthier physician, and a healthier physician provides better care.

Physician Resilience

"Timeo Danaos et dona ferentes," or "I fear the *Greeks*, even those *bearing gifts*."

Improving physician resilience has been touted as a tool to treat PBS. Dr. D. Drummond makes an eloquent analogy to the contrary that physicians are the canary in the coal mine of medicine, and states that the epidemic of PBS is an indictment of the conditions of the coal mine, not the resilience of the canary.[2] Thus, he argues, making a stronger more resilient canary is not the answer. Dr. Drummond defines resilience training as "the acquisition of any burnout prevention tool the physician puts to their own individual use. The tool increases the physician's resilience in the face of the stresses of their practice and workplace systems."[2]

When resilience training is instituted by a hospital or other healthcare organization it is met with caution and skepticism. Resilience training elicits a similar visceral response as “I’m from the government and I’m here to help.” It is generally viewed as one more thing to do, increasing the stress load on an already stressed physician population.

Resilience training can also imply to the physician that they are the problem, as with the metaphor of a sick canary vs. a sick environment or culture. Sometimes resilience training is interpreted as a sinister attempt by the organization to get more output from the physician.

For these reasons, it is important that when resilience training is offered, it is presented as a small part of a much larger strategy; the healthcare organization needs to show it is addressing PBS as a systems problem, not a physician problem.

Mindfulness-Based Stress Reduction

Mindfulness-Based Stress Reduction (MBSR) is an effective tool to decrease stress and prevent PBS. Again, the argument can be made that promoting an individually-obtained remedy gives a message that it is the physician who is broken and not the system. By now, we can all agree it is a systems problem. MBSR is a healthy way to deal with the system, to prevent PBS.

Developed in the late 1970’s at the University of Massachusetts Medical Center, MBSR is a mixture of science, medicine, and psychology with Dharma, or Buddhist, meditative traditions, teachings, and practices. It is used to help treat numerous conditions including anxiety disorders, mood disorders, substance abuse disorders, eating disorders, chronic pain conditions, insomnia, ADHD, and burnout syndrome.

MBSR promotes mind and body awareness to reduce the physiological effects of stress, pain, or illness. It emphasizes non-judgmental awareness in daily life while promoting serenity and clarity in each moment so one can experience a more joyful life and access inner resources for healing and stress management. There are education centers dedicated to mindfulness that have proliferated around Tennessee and the country that are open to the public.

MBSR is a powerful tool in the toolbox that physicians can utilize on a daily basis to promote wellbeing and joy in life, even if one has not been or is not yet impacted by PBS.

Summary

Physician Burnout Syndrome is characterized by exhaustion, cynicism, and loss of accomplishment. PBS is an organization and systems issue that is shown to influence quality of care, patient safety, and physician turnover, and can lead to depression and even suicide. An engaged physician workforce is critical for healthcare organizations to provide quality care and achieve fiscal goals.

Most organizations operate under the belief that it is the responsibility of individual physicians to heal themselves. While there are some meaningful actions a physician can take to prevent and treat PBS, most factors driving burnout are beyond the physician level, and some are even more systemic than the organizational level. However, organizational level efforts can greatly influence physician well-being. We all have heard about the proverbial “ounce of prevention.” That sage advice not only applies to clinical care, it is very applicable to physician health and the epidemic of PBS. The ounce of prevention in this case includes organization and systems changes, as well as strategies that involve the individual physician.

1. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017 Jan;92(1):129-146.
2. Eight Ways to Manage Practice Stress and Get Home Sooner. Fam Pract Manag. 2015 Nov-Dec;22(6):13-18.

See the Tennessee Medical Foundation's website here.

The Federation of State Physician Health Programs provides a comprehensive listing of state programs here.

Tips to Prevent Denied Claims

Denied claims cost your practice both time and money. Employees spend precious hours researching and processing denials, only to find that payers are unresponsive or unwilling to overturn their decision. Given the complexity of our reimbursement system, denied claims will always exist. However, there are certainly opportunities to reduce their prevalence, thereby decreasing their adverse impact on your practice's bottom line. Here are five strategies to address denial prevention.

1. Get to the root of the problem. Why are services being denied? When you can clearly answer this question, then you can address and – hopefully - fix the issue. To do so, look carefully at the remittance; you'll see a code – or several – that gives you the source of the problem. Be sure to address denials at the line item level, as a single claim may have multiple services – all of which may be denied for different reasons. Gather intelligence about the reason for denial; you might need to hone in on registration or authorization issues, or perhaps there are coding discrepancies. Ultimately, you can't fix the problem until you understand where it begins.

2. Verify insurance and benefits. Regardless of specialty, the majority of denials emanate from registration-related issues. Patients change insurance coverage on a frequent basis and often present with expired insurance. Verify active coverage and benefits eligibility for every patient, including those for whom you've rendered care outside of the office. Make every effort to confirm the patient's insurance prior to submitting the claim, and, ideally, before you've rendered the service.

3. Train, train, train. After you've gained some intelligence about the reasons related to denials, train physicians and advanced practice providers on why claims are being denied and how they can help. Consider choosing a "denial champion" – a provider who can be your partner in performance improvement. Host ongoing training for administrative and business office employees to ensure they are up to date on the latest information and procedures. This is a great chance to review terminology, coding issues, the appeals process, and the importance of preventing denied claims.

4. Create an appeals team. Although some denials can be addressed with a simple correction, many require the surgical precision of an expert. Assign a team to review and handle denials that require appeals; a team approach allows you to leverage the collective skills and expertise of the group. While a business office employee may still be the point person for processing, the team can meet every other week to resolve issues, provide guidance, and track efficacy.

5. Report denials. There's no doubt that denial prevention requires an understanding of the source of your denials. Delve deep, reporting denials by reason, as well as payer,

provider, and procedure code. By examining data at this level of detail, you may spot trends such as the consistent denial of payment for a service by a particular payer. This discovery may lead to conferring with patients prior to the service being rendered, if it is considered non-covered or experimental, or addressing it directly with the payer during contract negotiations.

Developing internal expertise to manage denials you commonly receive is vital to the success of your revenue cycle. While many practices seek to resolve denied claims, the true goal should be preventing them entirely.

****

The electronic remittance advice (ERA) from a payer includes codes that indicate the reason for a denial or partial payment. These codes are the claim adjustment reason codes (CARCs), which may be accompanied by further detail via remittance advice remark codes (RARCs). Ten common CARCs are listed here:

PR1 Deductible amount

CO11 The diagnosis is inconsistent with the procedure

CO15 The authorization number is missing, invalid, or does not apply to the billed services or provider

CO16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

CO18 Exact duplicate claim/service

CO22 This care may be covered by another payer per coordination of benefits

CO29 The time limit for filing has expired

CO31 Patient cannot be identified as our insured

CO55 Procedure/treatment is deemed experimental/investigational by the payer

PR119 Benefit maximum for this time period or occurrence has been reached

Notes:

PR=patient responsibility

CO=contractual obligation

See this page for a complete listing of the codes

ECRI Institute Reveals Top 10 Patient Safety Concerns of 2018

Each year, ECRI Institute – a nonprofit organization that researches approaches to improving patient care – identifies TOP 10 Patient Safety Concerns. This list identifies key areas to "support health care organizations in their efforts to proactively identify and respond to threats to patient safety." The 2018 list is as follows (items in **bold** are new to the annual list):

1. Diagnostic errors
2. Opioid safety across the continuum of care
3. Internal care coordination
4. **Workarounds**
5. **Incorporating health IT into patient safety programs**
6. Management of behavioral health needs in acute care settings
7. **All-hazards emergency preparedness**
8. Device cleaning/disinfection/sterilization
9. **Patient engagement and health literacy**
10. **Leadership engagement in patient safety**

According to ECRI's executive brief, in selecting this year's list, ECRI Institute relied on both data regarding events and concerns and on expert judgment. Since 2009 when the ECRI Institute Patient Safety Organization (PSO) began, ECRI and its partner PSOs have received more than 2 million event reports. The list does not necessarily represent the issues that occur most frequently or are most severe as the process synthesized data from these varied sources:

- Review of events in the ECRI Institute PSO database
- PSO members' root-cause analyses and research requests
- Topics reflected in weekly *Healthcare Risk Control Alerts (HRC)*
- Voting by a panel of experts from inside and outside ECRI Institute

This list identifies concerns that might be high priorities for reasons such as new risks, existing concerns that are changing because of new technology or care delivery models, and persistent issues that need focused attention or pose new opportunities for intervention.

Medical offices should be consistently assessing these targeted areas for improvement while also developing strategies to address concerns. For example, diagnostic errors are often related to systems errors such as inappropriate and ineffective usage of electronic health records (selecting the wrong template, workarounds), and failing to track lab,

diagnostic imaging, and referrals. Medication safety continues to be a top concern even in offices with advanced technology. Medical offices have the opportunity to make a significant impact in improving communication by incorporating some simple strategies including huddles, updating flow sheets and checklists, utilizing the teach back method for ensuring patient understanding of instructions, and effective use of patient portals for improved communication.

SVMIC encourages you to download ECRI Institute's executive brief for more detailed information and strategies to mitigate these risks. Please visit svmic.com for additional risk management resources.

Adapted from: *Top 10 Patient Safety Concerns for Healthcare Organizations 2018.* ©ECRI Institute | www.ecri.org.

2017 Scores Released: Merit-based Incentive Payment Plan

In July, the Centers for Medicare & Medicaid Services (CMS) issued the scores for the first year of the Quality Payment Program (QPP). Your 2017 Merit-based Incentive Payment System (MIPS) scores and performance feedback reports can be retrieved from the Quality Payment Program's website. These scores determine the adjustment – a payment boost or a penalty – that CMS will make to your 2019 Medicare rates. In addition to the scores, CMS released a fact sheet titled: *2019 Merit-based Incentive Payment System (MIPS) Payment Adjustments based on 2017 MIPS Final Scores*. As this information will impact your 2019 Medicare payments, let's review the action items based on CMS' recent announcements.

Check your score. The scores for your performance in 2017 were released; it's important to take the opportunity to review this information. If you disagree with the score for any reason, submit a request for a targeted review. Be prepared to provide supporting documentation for the assessment; applications are due by September 30, 2018, and decisions are binding.

***Determine the impact*.** In addition to the negative or positive adjustment to Medicare payments in 2019, recognize that your score will be reported later this year on Medicare's Physician Compare website. Furthermore, all of the data is slated to be released to the public, which will allow access to by media and researchers, as well as third-party suppliers, including rating websites such as HealthGrades.

***Lower your expectations*.** CMS had previously revealed that positive adjustments may not be as high as anticipated. In the *MIPS Scoring 101 Guide*, CMS opines: "it is anticipated that the positive adjustments may be considerably less than +4%." Because the program was constructed to be budget neutral, the fact that most physicians were successful reduces the opportunity to receive the maximum increase. This, combined with CMS' exemptions for all physicians in several states due to natural disaster in 2017, means that even successful physicians will only see small payment increases in 2019. Scoring 70 points or higher put physicians in the "exceptional performance" category to achieve boosts even higher than 4%, however, CMS reveals that "the amount of the adjustment is also applied on a linear scale…the amount of the adjustment is scaled and will depend on the scores and the number of clinicians receiving a score at 70 or higher." In the payment adjustment fact sheet, CMS reveals that "an additional adjustment factor of 0.5 percent is assigned to a final score of 70." The final maximum allowance is reported to be 2.02% - for a perfect score. In sum, the promises of 12% - the highest amount reported to be available for successful program participants – cannot and will not be obtained. The reason for this

conclusion – too many eligible clinicians were successful – is a great one in terms of participation, but it's disappointing for those who made a lot of effort, only to see a small return.

Recognize that it's hard to wipe the slate clean. If you were one of the few practices that did not successfully participate in MIPS in 2017, you may have considered altering your QPP identification number. A change to the Tax Identification Number (TIN) might have been an option, as CMS is applying payment adjustments to eligible professionals on the basis of unique TIN/NPI combinations. This is in contrast to the "meaningful use" penalties, which followed physicians on the basis of tracking by NPI only. The QPP was expected to be a reversal in course; however, CMS fails to provide a simple option to avoid problems associated with historical poor performance. CMS cites: "In cases where there is no 2017 MIPS final score associated with a TIN/NPI that's being used in 2019--because a clinician changed practices or established a new TIN--CMS will apply the payment adjustment associated with the NPI's final score under the TIN(s) the NPI was billing under during the 2017 performance period." Furthermore, practices that tried to add physicians to their group reporting after the final quarter started are in for a surprise as CMS declares: "Individual MIPS eligible clinicians who started billing to a group's TIN between 9/1/2017 and 12/31/2017 will receive a neutral payment adjustment for that TIN in the 2019 payment year."

Understand the impact of the payment adjustment on patients. CMS is applying its adjustment to the Medicare paid amount; as noted by CMS "…it does not impact the portion of the payment that a beneficiary is responsible to pay." Furthermore, CMS clarifies that the adjustments are for Medicare Part B covered services, and the adjustments will not extend to Medicare Advantage plans. These declarations further erode the financial benefits for successful participants. [1]

While there are many changes to the Quality Payment Program, it's time to take a pause in order to reflect on your 2017 performance. Accessing your scores today will avoid surprises come January, and may help you to determine how to best allocate resources to the QPP moving forward.

[1] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-MIPS-Payment-Adjustment-fact-sheet.pdf

Wrong Number Results in Security Breach

The following article is based upon an actual claim situation experienced by an SVMIC policyholder. The details have been altered to protect our policyholder's privacy.

Springtime in Arkansas brought pleasant temperatures as well as lots of mold and pollen, especially after the mild, wet winter. As a result, Dr. Smith*, a primary care physician, saw many patients with complaints of sneezing, congestion, coughing and sore throats. Most of the patients thought that they had a virus, but Dr. Smith often suspected allergies.

Dr. Smith had a good relationship with Dr. O'Donnell*, an allergist in the same medical office park who also treated Dr. Smith's children for their allergies. Dr. Smith referred any patients who needed allergy testing to Dr. O'Donnell.

Dr. O'Donnell's office was one of the few practices in the medical office complex whose EMR systems did not communicate with Dr. Smith's EMR system. Dr. Smith's office sent medical records including visit notes, lab and x-ray results via facsimile to Dr. O'Donnell's office for the patients who were referred. Lisa*, the Medical Referral Coordinator for Dr. Smith's practice, had Dr. O'Donnell's fax number written on a piece of paper and taped to her desk.

During one particular week, Lisa faxed records for 12 patients totaling approximately 105 pages. Unfortunately, Lisa had spilled some water on her desk and the ink on the piece of paper with Dr. O'Donnell's fax number was smeared, making it difficult to read. Lisa mistook the last digit, an "8", for a "3", and dialed the wrong number when faxing the medical records.

The incorrect fax number belonged to a distribution warehouse. Thankfully, the warehouse sent a fax to Dr. Smith's office advising that they had reached the wrong fax number. Lisa called the distribution company and the warehouse supervisor assured her that they had deleted the fax from their machine as well as shredded the paper copies that had been printed. In spite of the reassurances, there was no way of knowing how many people had seen the patients' medical records.

Fortunately, Dr. Smith had his medical malpractice insurance coverage with SVMIC and his policy included $50,000 of cybersecurity insurance coverage. Lisa reported the error to an SVMIC claims attorney, who then forwarded the information to NAS, SVMIC's partner in cybersecurity coverage. NAS was able to assist Lisa in determining how the practice should proceed in mitigating any damage caused by the faxing error.

Dr. Smith's cybersecurity coverage** not only provided assistance for a cyber-breach or cyberattack, but it also included coverage for "a claim for an actual or alleged security and privacy wrongful act." A "security and privacy wrongful act" as defined in the endorsement is "the failure to prevent or hinder a security breach, which in turn results in…the theft, loss or unauthorized disclosure of electronic or non-electronic confidential commercial, corporate, personally identifiable, or private information that is in an Insured's care, custody or control."

According to the Health and Human Services (HHS) website, the HIPAA Privacy Rule allows protected health information to be shared by covered providers for the purpose of treatment without patient authorization. There is no restriction as to how the information is to be communicated. However, the provider must have practical precautions in place.

The HHS website says the following regarding fax communications: "…when faxing protected health information to a telephone number that is not regularly used, a reasonable safeguard may involve a provider first confirming the fax number with the intended recipient. Similarly, a covered entity may pre-program frequently used numbers directly into the fax machine to avoid misdirecting the information." You may find more information regarding these guidelines here.

Having learned from this experience, Lisa instituted two mandatory procedures for sending faxes from Dr. Smith's office to avoid any further mishaps. First, she programmed Dr. O'Donnell's correct fax number, as well as any other fax numbers used by the practice, into the fax machine. Second, any time a fax containing protected health information is sent by the practice, a request for confirmation of correct recipient is faxed first and no information is sent until a response is received.

In addition to the cybersecurity coverage through NAS provided in SVMIC's medical professional liability policy, there are other tools available to our policyholders. SVMIC has partnered with NAS to bring our policyholders access to NAS cyberNET. This site features monthly cybersecurity updates, webinars and online training and support. Access this site at https://www.svmic.com/resources/cyber-security. In addition, SVMIC's Medical Practice Services offers consulting and training related to cybersecurity and HIPAA.

**All names have been changed.*

*** Cybersecurity coverage is subject to terms, conditions and exclusions not described in this article. The information contained in this article concerning cybersecurity insurance is intended to give you an overview of the coverage available. None of the information—including any policy or product description—constitutes an insurance policy or guarantees coverage. The policy contains the specific details of the coverages, terms, conditions and exclusions and coverage determination is made by the company at the time of a claim.*

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.