Don't Say "Sorry"

When your practice is running late, it is easy to greet the next patient with an “I’m sorry” instead of making a more meaningful connection. Although acknowledging the time and the patient’s frustration is a noble intention, a basic “I’m sorry” can actually start your appointment off on the wrong foot. Instead, try acknowledging the situation by making it more personal.

For example, you could share, "If I had an appointment with my doctor, I would be upset if she was running 30 minutes behind." Then, stop talking and allow the patient to express his or her feelings. This action alone can make a tremendous difference in the overall visit. If the patient is still frustrated, ask for permission to address the situation. For example, "Ms. Smith, may I step out of the room for just a moment to see what I can do?" This action achieves two results: Time away can further diffuse upset emotions and the patient's perception is that he or she has been taken seriously. There may be nothing you can do but return with a cup of water or tea, and let the patient know that the physician will be in within 15 minutes, yet this information can reassure a nervous or frustrated patient and make them feel heard and valued.

Another option is to state, “Thank you so much for understanding. We really appreciate your time and your patience. Is there anything I can bring you to make you more comfortable?” (Or, “May I bring you a cup of water to make you feel more comfortable?”)

An initial “thank you” can put the patient in a better frame of mind more than saying “I’m sorry,” making them feel more appreciated - and like you’re in this together. Even if not every patient leaves insisting that your operation is "five-star" practice, they will depart without immediately running to Yelp and posting a host of negative comments about your office and its schedule.

Naturally, this approach may not work every single time, but it will give you further time and space to potentially deal with the delay while giving the patient a chance to air his or her grievances. Ultimately, people want to be heard. Offering patients a chance to speak, particularly when they might be apprehensive about the appointment to come, is valuable regardless of the outcome. Consider opportunities for turning apologies into connections with patients to bolster your practice’s customer service.

Quality Payment Program: 2019 Adjustments

Medicare remittances began arriving for 2019 services in mid-January. Unless an exemption applies, physicians and other eligible clinicians will see a bonus – or penalty – attached to each service. The claim adjustment reason code (CARC) for a positive payment adjustment is CO144; the negative adjustment is designated by CO237. This penalty code is the same one used for failure to comply with Meaningful Use, the Physician Quality Reporting System, and other past programs. Both the positive and negative adjustments are accompanied by the remark code N807, which signals "payment adjustment based on the Merit-based Payment System."

Part B drugs are not subject to the positive or negative adjustment, according to the Centers for Medicare and Medicaid Services (CMS): "The payment adjustment won't apply to payments for Medicare Part B drugs or other items and services that are not covered professional services."

However, CMS made a mistake in claims processing, beginning January 1: "Recently, CMS discovered an error in the implementation of the 2019 Merit-based Incentive Payment System (MIPS) payment adjustment; it incorrectly applies payments for Medicare Part B drugs and other non-physician services billed by physicians." CMS identified the issue in early February, but the processing of claims continues to reflect the mistaken adjustment. Physicians should be aware that CMS will retroactively correct this error – in other words, they will get their money back. This holds true for those who paid a positive adjustment on Part B drugs – a circumstance that occurred for the majority of physicians participating in the program, including nearly 80 percent of physicians who reached the "exceptional performance" zone. CMS has declared its intention to recoup these mistakenly paid bonuses; they will be extracted from future transactions by automatically deducting the payment from claims.

In terms of the patient's financial responsibility, the payment adjustment is applied to the Medicare paid amount, therefore, it does not impact the portion patients are responsible for paying.

If a physician participates with a Medicare Advantage plan(s), the degree of the adjustment, and whether it is extended at all, is not dictated or regulated by CMS. Per CMS

, “The Social Security Act prohibits [us] from interfering in payment arrangements between MAOs [Medicare Advantage Organization] and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO’s payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician”.

Adjustments are displaying on Medicare remittances this year for physicians’ performance in 2017. Efforts made now will determine your ability to gain an unknown bonus in 2021 – or stave off the Quality Payment Program’s 7 percent penalty.

Federal HR Changes May Impact Your Practice

Overtime is common in medical practices, so it is important to understand the regulations associated with it. On March 7, the Department of Labor (DOL) announced an overtime update that could impact your practice. The DOL's proposal raises the salary threshold for exempt employees from $23,660 to $35,308 per annum. This increase would shift the number of employees who are required to be compensated on an overtime basis, increasing it to be required to an estimated one million more Americans.

Unless exempt, employees must receive at least 150 percent of their regular pay for any hours worked above 40. This proposal would potentially move employees out of this category, although it's important to note that meeting the salary threshold is only one test. The employee's responsibilities also must comprise primarily of administrative, executive or professional duties. If your practice hasn't done so lately, it's an opportune time to seek guidance from your HR consultant/attorney – and/or to conduct audits of exempt status. We will keep you updated on this hot topic. For more information, see here.

Communication is in the Eye of the Beholder

Over the years, SVMIC has emphasized the importance of effective communication as it relates to providing medical care. The physician should attempt to effectively communicate with patients as well as with other healthcare providers. Patients sometimes claim after the fact that they didn't really understand the physician's orders, including what the physician recommended the patient should do as a part of the course of treatment. Communication between physicians is also important. SVMIC has had cases in which physicians reported that, if another physician had better communicated to them the condition of the patient, the course of treatment would have been different. The following case is one in which communication with the patient and with other physicians could have been improved.

Jennifer Smith [1]was a 33-year-old female patient who had a medical history which included a diagnosis of hydrocephalus for which a right ventriculoperitoneal shunt was implanted shortly after her birth. Ms. Smith had shunt revisions at 2 years and at 9 years of age. As a toddler, she was also diagnosed with epilepsy.

Ms. Smith began treatment with Dr. Mark Taylor, a neurosurgeon, and Dr. Edith Russell, a neurologist, in 2013 and 2014, respectively. They practiced in the same large multispecialty physician group. In November 2013, Ms. Smith saw Dr. Taylor for implantation of a Vagal Nerve Stimulator (VNS) to control her seizures. The procedure was performed later that month with no complications. Ms. Smith began seeing Dr. Russell in September 2014 for management of the VNS device and medication management.

In November 2014, Dr. Russell prescribed Ms. Smith an antiepileptic in order to reduce seizure activity. The drug proved effective, but in June 2015 the patient began experiencing blurred vision. Believing it was a side effect of the antiepileptic, Dr. Russell ordered the medication levels checked and instructed the patient to see an ophthalmologist.

In August 2015, Ms. Smith saw Dr. Russell in follow-up and she voiced new complaints of headaches, numbness, and double vision. She stated that she had seen an ophthalmologist who told her there was "something wrong" with her vision, but did not give an official diagnosis. Dr. Russell asked her office staff to request a copy of the patient's ophthalmology records, but this request was accidentally overlooked. Ms. Smith also stated that she had been to the ER twice for her headaches, and that the attending physician had been "worried about her shunt." Dr. Russell again urged the patient to follow up with an ophthalmologist.

In September 2015, Ms. Smith called Dr. Russell's office and complained of continued headaches. The patient stated she had been to the emergency room due to the headaches

and a lumbar puncture had been performed. She reported to Dr. Russell that she was still having headaches when sitting upright. Dr. Russell believed the patient was suffering from low CSF headaches from the lumbar puncture, so she advised Ms. Smith that she needed a blood patch.

Dr. Russell instructed the medical receptionist to schedule the patient for an office visit, blood patch, and labs. However, the medical receptionist could not locate the patient to relay that information or to make an appointment. The details of the communications are not clear, but Ms. Smith's husband called the clinic two days later and told the staff that he was taking his wife to a local hospital to get a blood patch. Dr. Russell thought that a blood patch had been performed, but found out later that it had not.

Soon thereafter, in early October 2015, Ms. Smith was seen again by Dr. Russell because she was nauseous and "passing out." She also had severe headaches with pain radiating down her back, right arm and leg. Dr. Russell performed a fundoscopic eye exam, and a visual field exam, and observed for the first time swelling around the patient's optic discs. She diagnosed the patient with papilledema and ordered an MRI, which showed the shunt in place with no hydrocephalus. Dr. Russell referred the patient to Dr. Taylor for evaluation of the shunt. She again told Ms. Smith she needed to see an ophthalmologist.

Ms. Smith was seen by Dr. Taylor in early November 2015. She voiced new complaints of difficulty walking and increased confusion. Her MRI and a shunt series X-ray were negative, so Dr. Taylor did not recommend surgery except "as a last resort." The next day, Ms. Smith was seen by Dr. Russell. She ordered a CT of the cervical spine to rule out nerve impingement as a potential cause of the headaches, neck pain and numbness. It was normal. The patient admitted she had still not followed up with an ophthalmologist. So, Dr. Russell referred Ms. Smith to Dr. William Miller, an ophthalmologist who worked at the same clinic, to be evaluated for vision issues.

Dr. Miller saw Ms. Smith in early December 2015 and he confirmed the diagnosis of papilledema. He referred the patient to the ER of a local hospital for imaging studies and possible shunt revision. Imaging studies showed the shunt was in good position with no intracranial processes, no disconnection, and no complication. However, given Ms. Smith's symptoms, she was admitted for shunt revision surgery.

Dr. Taylor performed surgery for "likely shunt malfunction" on December 9, 2015. According to Dr. Taylor's operative note and personal reflection, the shunt appeared to be working properly and was not causing any problems. However, a pre-operative MRI showed some sluggish flow; therefore, out of an abundance of caution, Dr. Taylor decided to replace the entire shunt. There were no intraoperative complications and no mention of the shunt malfunctioning. After the uncomplicated shunt replacement, Dr. Taylor told the family that he had cut the old shunt in two places to remove it; they later claimed that he said the shunt was broken in two places.

Ms. Smith recovered well from surgery, and her headaches decreased. However, her vision continued to worsen. As of May 2016, she was almost completely blind in her left

eye and had 20/30 tunnel vision in her right eye.

Ms. Smith filed a lawsuit against Dr. Taylor, Dr. Russell, and their clinic. The lawsuit alleged that Dr. Taylor and Dr. Russell failed to timely act upon signs and symptoms of alleged shunt malfunction in October and November 2015, causing the plaintiff to suffer irreversible vision loss in both eyes. The plaintiff's claim against the clinic was that it failed to have proper procedures in place to facilitate communication between physicians and to ensure timely procurement of outside medical records. The plaintiff disclosed a neuro-ophthalmologist and a neurologist as expert witnesses in the case. Both of the plaintiff's experts were critical of the care and opined the papilledema should have been urgently addressed to prevent loss of vision. The plaintiff also disclosed a practice administrator as an expert witness who stated in her disclosures that the clinic failed to have appropriate policies and procedures or a proper EMR in place to ensure Ms. Smith's relevant ophthalmologic history was known to her providers, to ensure she was timely evaluated by an ophthalmologist, or to facilitate communications between the clinic's neurology and neurosurgery departments. As a side note, after the suit was filed and all of the patient's medical records were obtained through the discovery process, Dr. Russell learned that the patient had seen an optometrist in 2015 – not an ophthalmologist.

Dr. Russell felt the patient's papilledema was a chronic condition rather than an acute condition, which would have been a situation in which time was of the essence. When Dr. Russell made the diagnosis of papilledema, an appointment was made with Dr. Taylor, whose office is across the hall from Dr. Russell's office. Dr. Taylor testified in his deposition that he was not aware of the papilledema diagnosis when he assessed Ms. Smith, and if he had been aware of the diagnosis, he would have referred Ms. Smith to an ophthalmologist.

The defendants had a difficult time finding expert witnesses who were fully supportive of the medical care provided by Dr. Taylor and Dr. Russell. The potential defense expert witnesses felt that Dr. Taylor and/or Dr. Russell deviated from the standard of care by not acting in a timely manner after the diagnosis of papilledema. Another expert thought that the presence of headaches and visual changes should have been considered indicative of a shunt malformation until proven otherwise. Because the flow through the shunt was sluggish, intracranial pressure was building over time.

Our causation defense was bolstered by the fact that Ms. Smith contributed to her injuries by not being cooperative in her care and by self-managing her medications. She failed to see an ophthalmologist as ordered, she failed to take her medications as ordered, and she was generally difficult to get in touch with. She had multiple family members making calls to the office on her behalf, who relayed less than accurate information at times. However, it was undisputed that Ms. Smith's vision loss was most likely caused by papilledema, which was caused by increased intracranial pressure, which caused permanent damage to the optic nerves sometime in November 2015.

If the communications between the physicians and the patient and the communications between the physicians themselves had been clearer in this case, the patient's loss of

vision might have been avoided. The patient testified in her deposition that she did not know the difference between an ophthalmologist and an optometrist. Explaining the difference in those terms might have improved the patient's outcome. Making the referral to the ophthalmologist within their own clinic in a more timely manner may have improved the patient's outcome. Also, Dr. Taylor testified in his deposition that he did not know of Dr. Russell's diagnosis of papilledema when he began treating the patient. Explaining the reason for the referral to Dr. Taylor might have also improved the patient's outcome. Given the breakdown in communications and the patient's medical condition, a mediation was scheduled to try to resolve this case. A settlement was reached at the mediation. Improved communications with the patient and between the physicians might have improved the patient's outcome and may have avoided the loss payment made in this case.

[1] All names have been changed.

Potential Risks and Pitfalls of EHR Systems - Part I

Electronic communication has revolutionized the care provided within healthcare. The ability to exchange healthcare information electronically and the utilization of electronic health records gives providers the opportunity to provide higher quality and safer care for patients while creating measureable benefits for the organization. Through the use of electronic communications, providers gain opportunities to better manage care for their patients and provide better healthcare by having accurate and complete information about patients available at the point of care. It also enables safer, more reliable prescribing, easier and more accurate diagnosis of patients, promotes complete and legible documentation and allows streamlined coding and billing. Unfortunately, the technology intended to make professional lives easier and provide better patient care is creating new and additional risks for the healthcare provider. This article is a brief overview of some of the most common pitfalls that create potential liability for the practitioner.

To begin, it would be impossible to overemphasize the importance of maintaining complete and accurate medical records regardless of the format. Whether in electronic form or paper chart, the medical record WILL BE the most important piece of physical evidence in a malpractice trial. Therefore, completeness and accuracy are of utmost importance.

One of the primary causes of erroneous records is “digital assists.” Every EHR system utilizes digital assists, short cuts designed to improve efficiency and save time. When used properly, they serve their intended purpose. However, if used improperly, the result is a medical record that is inaccurate, incomplete, and unreliable, containing duplicitous carryover information that is often outdated. Although they are known by many names, some of the most popular digital assists/shortcuts are: “templates,” “copy and paste,” “auto-population,” and “cloned notes.”

In some systems, a template may be created based on checking a list of systems. As the patient visit progresses, it may become apparent that the template selected may not be the correct one. In those cases, the provider must make necessary changes to ensure the visit note accurately reflects both the care provided and the practitioner’s thought processes. Although it can be helpful to have a template to use as a starting point for documentation of a patient visit, it can easily lead to over-documentation. Hurriedly clicking checkboxes and failing to deselect boxes can inadvertently result in a two- to three-page office note that includes systems that were not assessed or care that was not provided. This over-

documentation can increase liability exposure if it does not accurately reflect what took place.

Similarly, the use of templates or click boxes can create an inaccurate clinical picture, potentially failing to accurately describe the complexity of the patient's condition because of the limitations created within the template itself. Because a template can prompt review of certain systems, or guide the assessment to seek specific findings, some providers may be misled to look for only those findings or diagnoses. As a result, a template can create tunnel vision that makes it easy for the provider to overlook other significant clinical findings, resulting in a delay in diagnosis or treatment of the actual problem.

The copy-and-paste function creates the capability to produce an office note by using a previously documented assessment. While there may be clinical reasons for a practitioner to review the notes from the patient's last visit to determine whether or not symptoms have resolved or worsened, the use of a "copy and paste" capability to create the new note from the old note is fraught with potential problems.
Copying information from a prior note and pasting into a new note can result in notes which are identical for multiple office visits. This is particularly risky for a physical examination where the patient's conditions may have changed since the prior visit and the record does not accurately reflect the complexity of the patient's condition.

Copying and pasting may result in irrelevant over-documentation perpetuating outdated or incorrect information and producing voluminous progress notes that obscure important new information. Copying and pasting entire x-ray reports or lab data into notes only adds to the problem. This practice can further result in entries with errors that are repeated in multiple office notes, becoming 'immortalized'. This is particularly apparent when typographical errors and non-standard abbreviations first used in the initial entry are carried over into subsequent notes. "Auto population", like templates, allows the EHR system to pre-fill information in specific areas of the medical record as a means of creating a short cut or improving the efficiency of the documentation process.

Most EHR systems contain check boxes for the practitioner to use to select symptoms and findings that reflect the patient's condition. These check boxes often are connected to templates. When a template is selected, certain fields in the EHR are automatically filled with the "canned" or pre-selected text. This text can be diagnosis-specific and the checkboxes may be pre-selected based upon the template selected. These auto-populated fields can include both normal and abnormal findings. The physician must make a note to know what information is auto populated so that he or she can review those observations and edit as needed.

Another type of auto population in EHRs occurs when certain fields in the patient's medical

record are completed with information from data fields in a previous office visit. This may occur through auto population of the office visit note itself or in specific sections of the record, such as the medical or surgical history.

In order to avoid compromising the integrity of the entire medical record, the provider should be aware of those areas of the medical record that are auto populated and carefully review the office visit notes An inaccurate record may lead to errors in the decision-making process, resulting in an ineffective treatment plan that will be difficult to defend in a court of law. It is very difficult to explain conflicting entries to a jury. When the chief complaint in review of systems is not consistent with the exam and assessment, it appears to be sloppy and the entire medical record is called into question. Some EHRs will not allow editing or correction of entry errors made in progress notes.

While the error may persist in several locations in the EHR, which cannot be edited, upon discovery, it is nevertheless important to create an addendum to correct the error. It should be clearly identified as an addendum with the reason(s) for correcting the error stated. To avoid the appearance of being self-serving, an addendum should not be written after an adverse event and certainly not after a claim has been filed or asserted without first speaking to a Claim Attorney.

Patients and juries alike want to see individualized care. A major problem with digital assists/shortcuts is that, when used incorrectly, they give the appearance of “cookie cutter” medicine and show a lack of attention to the patient. The best way to overcome this in an EHR is by using the patient’s own words wherever possible in the documentation. If a patient describes her pain as feeling as if someone stuck an icepick in her, document that in the narrative portion of the EHR in quotation marks as patient described pain as, “feeling as if someone stuck an icepick in her”.

The timeliness of the documentation is critical in order to ensure that the information is accurate, complete, and does not appear suspect. Office notes and procedure notes should be completed, reviewed, and signed within twenty-four to forty-eight hours. If the notes are not completed contemporaneously, any intervening event between when the patient was seen and the documentation was completed can make the documentation appear self-serving.

From a billing perspective, keep in mind that notes must be completed and signed prior to submission for payment. A problem that often arises with billing is cloned notes. Cloned notes may have entries worded exactly like previous entries, may lack specific individual information, and may give the appearance that every patient visit details the exact same problem, symptoms, and requires the exact same treatment. If notes are audited by CMS or a private payer and appear to be cloned, this may raise red flags about whether the

actual care was provided to support the level of coding billed.

If notes are left in an unlocked state in the EHR, potential risk exists because staff or subsequent providers may unintentionally modify the notes. This could affect patient safety due to future treatment decisions based on the incomplete or altered information. Moreover, in the event of a lawsuit, modifications made after the initial visit note may appear inconsistent, self-serving, and create other hurdles with defensibility. In addition, submission of billing prior to the signature and locking of notes may appear fraudulent.

The adoption of a new EHR system almost always requires changes in office/hospital processes and work flows. Couple this with the fact that not all physicians and staff are comfortable with the use of the EHR system, (or that they are required to use different EHR systems at different locations - hospital vs. office, for example) and it may lead to the creation of work-arounds to accomplish the same level of productivity that was achieved prior to the adoption of the EHR system. Unfortunately, these work-arounds may not reflect the “complete picture” and may lead to inconsistent processes, which can be very confusing and frustrating.

Training and consistency is the key to avoiding systems errors. When staff covers for other staff, if not properly trained, they will have varying differences for the same processes that may lead to ineffective tracking, patient notification of test results, and/or follow-up. This could have an end result of a devastating medical error or delay in medical diagnosis. It is important that everyone on the team be trained and familiar with the EHR system and they all use it in a consistent manner.

Avoiding the pitfalls of inconsistent processes can only be accomplished with a practice-wide focus on the creation of standard processes for use with the EHR. If an EHR system is not meeting the provider’s needs, a provider can work with the vendor rather than allowing staff to create individual work-arounds.

Utilization of an EHR can promote patient safety, improve accessibility of information and enhance continuity of care. However, the adoption of any new technology can have unintended consequences. Having an awareness of the potential pitfalls is the first step to ensuring notes are an accurate representation of the patient findings and treatment provided. In part two, to be published in the April 2019 edition of The Sentinel, we will examine audit trails and laws surrounding EHRs.

---

change over time.