The Rest of the Story

“The memories of men are too frail a thread to hang history from.” John Still

Paul Smith[1], a 52-year-old male, presented to the emergency room in a small community-based hospital with complaints of chest pain, shortness of breath, and nausea. Mr. Smith was quickly triaged and shortly thereafter Dr. Steve Andrews began his initial assessment. The patient underwent a chest pain protocol work up, including an EKG and lab work. The troponin level returned at 0.10ng/mL (N<0.01ng/mL). This caused the patient to fall within the facility’s classification for moderate risk of myocardial infarction. The EKG machine indicated that the EKG was abnormal based upon its computerized algorithm, but it was not indicative of an acute cardiac event. The patient was given a GI cocktail and monitored over the course of several hours and then discharged with a diagnosis of unspecified chest pain. Instructions were given for the patient to follow-up with his cardiologist, take Nitroglycerin sublingually, and to return as needed.

Exactly one week later, a family member found the patient collapsed on the floor at his home. EMS was called and resuscitation efforts were unsuccessful. The patient was taken to the local hospital where he had been treated the prior week and announced dead upon arrival.

A lawsuit was filed by Mr. Smith’s estate seeking damages for the wrongful death of Mr. Smith due to alleged negligent care provided by Dr. Andrews. The lawsuit asserted that Dr. Andrews needed to admit the patient, consult with a cardiologist, or transfer the patient to a tertiary care center for treatment. Based upon the facts noted above, one may be surprised to learn that Dr. Andrews was shocked to be named in the lawsuit and could not believe the accusations that were being lodged against him. Variations of this fact pattern are seen time and time again in malpractice litigation. A patient is determined not to be having a cardiac event in the ER and then discharged only to suffer a fatal cardiac event within a few days of discharge, making it easy to second guess the decision making process of the ER physician.

The Complaint that was filed was based upon the information that had been documented in the medical record. All who reviewed the medical record, including the defense experts, noted that the documentation was scant. The rest of the story in this situation is not what was *in* the medical record but what was *not* in the record.

Now Dr. Andrews’ view:

Dr. Andrews recalled the events of Mr. Smith’s presentation to the ER quite well because he had learned that Mr. Smith had died and recalled that he seen him the previous week in the ER. Dr. Andrews recounted his handling of the care while it remained fresh in his mind.

After doing so, he felt that he had managed the case in an appropriate fashion.

Dr. Andrews walked in to see Mr. Smith and, despite his complaints of pain, he was well enough to have a friendly discussion about some mutual friends, as this was a small community. Dr. Andrews inquired about Mr. Smith's past medical history, and Mr. Smith related that he had a history of chest pain and discomfort over the last several months and had been evaluated by a cardiologist. The cardiologist had diagnosed him with moderate coronary disease and had prescribed nitroglycerine to be taken as needed for chest pain. Just the day before, the cardiologist had stated that he felt that the patient's symptoms were related to a hiatal hernia and had made a referral to a gastroenterologist for further evaluation.

Dr. Andrews was concerned by the patient's level of pain, which was described as a 10/10, and this pain level had resulted in the patient coming to the ER for assessment, as the symptoms were not new. After the work-up described above, Dr. Andrews remained concerned about a possible cardiac event and recommended that the patient be transferred to a tertiary care center for further evaluation due to the abnormal EKG and pain level. Dr. Andrews had spoken to a physician who was willing to accept the patient with a cardiac treatment center, but Mr. Smith refused (or declined) the transfer since he felt much better after receiving the GI cocktail. Dr. Andrews was uneasy discharging the patient. However, the patient's explanation that he had been evaluated by his cardiologist and the fact that the patient's cardiologist had just concluded that the chest pain was not believed to be cardiac-related caused Dr. Andrews to acquiesce to the patient's request. The patient's chart was noted to simply reflect a diagnosis of unspecified chest pain with instructions to follow-up with the patient's cardiologist. Dr. Andrews relied exclusively on the history provided by Mr. Smith related to the cardiac work-up and did not confirm or discuss Mr. Smith's presentation with the treating cardiologist. However, the information conveyed was ultimately proven accurate.

Unfortunately, the documentation of the full discussion of the past medical history and the decision making process was absent from the medical record. Dr. Andrews did not feel the need to document in detail the interaction and only put minimal documentation in the chart. Instead, Mr. Smith and he had agreed upon what Dr. Andrews believed was a reasonable course of action in light of the fact that the patient's cardiologist had just determined that the patient's symptoms were not cardiac related the day before this ER visit. The desire of Dr. Andrews to transfer the patient for further assessment, the phone call placed to the tertiary care center, and the patient's declining this transfer was likewise not documented. When the patient died just a week later, the patient's family (who was not present for the ER visit and only had the medical records to recount the events of the day) consulted with an attorney, and the decision was made to file a lawsuit against Dr. Andrews.

While no one knows for certain, if the medical record had more fully documented the patient encounter, a lawsuit may never have been filed. Based upon the medical record only, the family was able to secure an expert who opined that Dr. Andrews had not done enough at this ER presentation and that his care was beneath the standard of care. Dr.

Andrews provided testimony in his deposition about the entirety of the events related to his treatment of Mr. Smith, but the plaintiff's attorney attempted to discredit Dr. Andrews' version of the events due to the lack of documentation. In the end, the documented medical record and Dr. Andrews' deposition testimony created a fact question that would ultimately need to be determined by a jury if not resolved through settlement.

It is impossible to document every event that occurs in the physician/patient interaction, but only a few additional facts documented in the medical record could have made this case appear quite differently to an outside observer. When medical malpractice claims are brought, the medical judgment is evaluated based upon the reasonableness of the decisions made. It is key that the important facts be documented and, while Dr. Andrews felt his decision making was sound, he acknowledged after-the-fact important details had been omitted from the record which hampered his defense. In the end, Dr. Andrews wanted the case to be settled because he was concerned that a jury might not find his testimony to be credible. It was unfortunate because contemporaneous documentation would have almost entirely removed this credibility issue and would have allowed the case to rise and fall on the medical decisions, which Dr. Andrews believed were appropriate under the circumstances.

[1] All names and identifying information have been changed.

An Analysis of Otorhinolaryngology Closed Claims

A review of paid otorhinolaryngology claims from 2009-2016 revealed that inappropriate surgical technique/treatment and failure to diagnose were the most common allegations. Often times the failure to timely diagnose was not the result of a lack of clinical judgment or medical expertise, but rather, was the result of the failure to follow up on a test result or missed appointment or the mishandling of a telephone message. Consistent systems and processes are crucial to ensure continuity of care.

Inadequate documentation was noted to be present in over half of the cases reviewed and was the most prevalent factor contributing to the inability to defend against allegations of inappropriate technique/treatment. One example involved a 59 year old obese patient with an extensive medical and surgical history who underwent a colon resection for adenocarcinoma. The insured ENT physician was consulted post-operatively and agreed a tracheostomy was advisable in the face of long-term intubation. The patient's hospital course was remarkable for sepsis, respiratory compromise with subglottic stenosis, pulmonary edema, atelectasis with pleural effusions and repeated failed extubation attempts. The patient was discharged home with the tracheostomy tube in place. Insured removed the tube in his office 3 weeks later. The patient arrested and died at home several hours after the removal. The lawsuit alleged negligent removal of the tracheostomy tube. Complicating the defense of this allegation was the fact that the insured ENT had virtually no documentation to support his assertion that he did a proper assessment and evaluation of the patient's respiratory status before and after removal of the tracheostomy tube. The fact that the patient died shortly after extubation, along with numerous notes in the hospital record by the treating pulmonologist that the physician removing the tracheostomy tube should carefully evaluate the subglottic area prior to tube removal, led to the settlement of the case.

In another case, a 5 year old patient, with a history of asthma, underwent an uneventful adenotonsillectomy with ventilation tubes. Shortly after being transferred from recovery to the floor, the patient developed an adenoid bleed. The insured ENT was called and elected to treat the bleeding with Neosynephrine and a FloSeal injection. Shortly thereafter the patient began coughing up large amounts of blood and clots and was returned to the operating room where the bleeding was controlled. However, the child developed respiratory symptoms requiring hospitalization for several weeks. The plaintiffs asserted that the ENT was negligent in opting to treat the post op bleeding with the Neosynephrine

and FloSeal rather than proceeding immediately with surgical intervention. They argued that the patient aspirated blood, which caused the prolonged respiratory problems. The defendant physician argued that such treatment was appropriate and, in fact, the bleeding did stop following the initial treatment and that the patient's respiratory issues were most likely secondary to exacerbation of asthma rather than the bleeding. Unfortunately, there was no documentation to support his assertion that he (1) examined the patient to determine the source of the bleeding and (2) confirmed that the bleeding had stopped following administration of the Neosynephrine and FloSeal. Without documentation to corroborate the physician's assertions, the plaintiffs were persuasive in arguing that the patient, in fact, continued to bleed following application of the Neosynephrine and FloSeal and therefore aspirated the blood due to the nasal occlusion with Floseal.

Communication breakdowns likewise played a part in the initiation of a number of the claims reviewed as well as the indefensibility. Problems with communication were identified in 28% of the claims reviewed, nearly all of which involved direct physician to patient breakdowns. The failure of the physician to discuss material and significant risks associated with the procedure, as well as expected outcomes, most often led to unrealistic expectations on the part of the patient which, in turn, resulted in frustration and dissatisfaction in the face of a complication. Further, the failure to document the process when complications did occur, provided the opportunity for the plaintiffs to contend that they did not receive the relevant and required information needed to make an informed treatment decision, and, if they had, would have sought a more conservative course or a second opinion. Specifically, lack of informed consent was alleged when a patient suffered a cribiform plate injury during an endoscopic nasal polypectomy as well as when another patient suffered injury to the optic nerve during endoscopic sinus surgery, resulting in total blindness in one eye.

Surgical burns were the cause of a number of claims reviewed. Several cases involved bovie burns during tonsillectomies. One case involved ChloroPrep solution, which was inadvertently splashed into the patient's eye during surgery for tumor removal which caused a corneal burn and scarring.

Lessons Learned:

- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up at subsequent visits.
- Ensure 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 for staff to track and for providers to personally review results.
- 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 time frame.
- There should be an established system for tracking patients who miss follow-up appointments. If a patient misses or cancels a follow-up appointment, it should be documented and investigated. Appropriate efforts should be 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 closely monitored.

- Review the results of all tests ordered pre-operatively to ensure any abnormalities receive proper attention and follow-up.
- Document completely – including history, instructions and telephone calls as well as the rationale for actions that may not be self-evident. Such documentation not only enhances patient care, but bolsters your credibility if you are called upon to defend such care.
- Complete documentation within 24-48 hours of the office visit or procedure. Late completion of notes puts you and your colleagues at risk. Memory interferes with accuracy and efforts to "catch up" often lead to incomplete documentation. Any intervening adverse event prior to completion of notes makes late documentation appear self-serving.
- Clearly communicate with patients when providing medical advice over the telephone. Use the teach back method to ensure an understanding of the information relayed. At a minimum, the following types of phone calls should always be documented in the medical record: when test results are reported, when the patient is advised to return to the office or go to the emergency room, and patient requests for medical advice or prescription refills.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, expected outcome, possibility of an additional or different procedure if indicated, and alternatives. Doing so not only discharges your legal and ethical obligation to provide patients with sufficient information with which to make an educated election about the course of their medical care, but may help create realistic expectations as to the outcome of treatment. Be careful not to educate above the patient's comprehension level. Be sure the details of all discussions with patients are documented in your office record rather than relying on hospital consent forms, which are not procedure specific and may not capture all details of the conversation.

- Provide clear, detailed, understandable, procedure-specific written postoperative instructions to patients. Patients who have a clear understanding of what signs and symptoms to watch for, how medication should be administered and when to make follow-up appointments are less likely to be readmitted or visit the emergency department.
- Ensure that the entire surgical team is aware of and follows surgical burn safety procedures and protocols. During the surgical time out, communicate with the team about fire and burn risks and the planned course of action in the event of an incident.
- Electrosurgical equipment should be evaluated for damage (e.g. insulation, cables, connectors, return plates) and proper working order confirmed prior to the start of surgery. When not in use, electrosurgical equipment should be placed in a holster and not on the patient or surgical drapes.

It's Not Too Late to Vaccinate

Last month, the CDC issued a letter to healthcare providers asking for help to ensure patients receive influenza vaccines **by the end of October**. The letter states "…To avoid missed opportunities for vaccination, providers should offer vaccination during routine health care visits and hospitalizations when the vaccine is available. Vaccination efforts should continue throughout the season because the duration of the influenza season varies and influenza activity might not occur in certain communities until February or March…" Flu vaccine risks are generally low, but the CDC reminds you to "know the site and get it right," to prevent shoulder injuries such as tendinitis or even deltoid bursitis, generally caused when vaccines are injected high on the shoulder and the needle enters a shoulder bursa. Train staff to use the correct syringe and needle and adhere to the "Five Rights"(right patient, right drug, right dose, right route, right time). Follow these safe injection practices for adults: maintain aseptic technique, perform hand hygiene, and use a new needle and syringe for each injection.. If using a single-dose vial, you must use it for only one patient and discard after use. The CDC also recommends drawing up vaccines only at the time of the administration.

Staff should be aware of precautions that can be taken to reduce the likelihood of fainting and falls after vaccine injections here. Providers should have a medical emergency plan in place in the event of a severe acute vaccine reaction.

All vaccine providers, public or private, are required by the National Vaccine Childhood Injury Act to give the appropriate Vaccine Information Statements (VISs) to the patient (or parent or legal representative), regardless of the age of the recipient, prior to every dose of specific vaccines, including the influenza vaccine which is available here. The VIS may be read or reviewed electronically by the patient/legal representative and the provider must offer a copy, but the recipient may decline.

Remember to report any clinically significant adverse event to the Vaccine Adverse Event Reporting System (VAERS) here.

For additional information the on VISs and proper vaccine administration, please see this page. For information on vaccine storage and handling, visit this page.

Billing Medicare for Preventive Services

Can I bill Medicare for Depression Screening?

What is the CPT® code for Medicare's Initial Preventive Physical Exam?

How many smoking cessation sessions will Medicare cover for my patient?

Do all males qualify for Prostate Cancer Screening?

Which counseling services can I provide via telehealth?

It is hard enough to keep up with the requirements for evaluation and management (E/M) services, so it is not a surprise that many practices perform additional services without billing them. Armed with knowledge, however, you can overcome the "how do I bill this?" problem, as well as remain compliant. Plus, accurate information leads to a boost in revenue, particularly if you're already performing the services – and just not billing for them.

This article highlights Medicare, which has specific CPT® codes and coverage requirements for preventive services. We could write a book on this topic, however, let's take the opportunity to answer the questions you've posed – and direct you to an exceptional resource to answer frequently asked questions:

Call I bill Medicare for Depression Screening?

Yes, once annually using G0444 (Annual depression screening, 15 minutes). There is no out-of-pocket cost to the patient. All Medicare patients are provided this coverage, although CMS notes: "Screening must be furnished in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up."

What is the CPT code for Medicare's Initial Preventive Physical Exam?

Also known as the "Welcome to Medicare" Visit, the code is: G0402 (Initial preventive physical examination; face-to-face visit). The service is limited to new beneficiaries during their first 12 months of Medicare enrollment, with no out-of-pocket cost to the patient. Additional codes are available for an EKG, however, the copayment/coinsurance applies.

How many smoking cessation sessions will Medicare cover for my patient?

Two attempts are covered per year, with a maximum of four sessions per attempt. Therefore, eight sessions per year are covered, with no out-of-pocket cost to the patient. The codes are 99406 (intermediate, >3 minutes up to 10 minutes) and 99407 (intensive, >10 minutes). Note that specific ICD-10 codes are required for coverage.

Do all males qualify for Prostate Cancer Screening?

Medicare pays for male beneficiaries aged 50 and older, noting that coverage begins the day after the patient's birthday. There are two CPT codes – the digital rectal examination (DRE) should be coded as G0102, and the prostate specific antigen (PSA) test coded with G0103. The PSA is fully covered by Medicare, with no out-of-pocket cost to the patient, while the patient has financial responsibility (copayment, coinsurance and deductible) for the DRE. The benefit is provided once annually, and the only diagnosis code that is accepted is Z12.5 (Encounter for screening for malignant neoplasm of prostate).

Which counseling services can I provide via telehealth?

A multitude of services are now fully covered by Medicare when furnished via telehealth. They include alcohol misuse screening and coverage, annual wellness visit, counseling to prevent tobacco use, depression screening, medical nutrition therapy and more.

Bookmark this website, which provides comprehensive information about coverage for preventive services. There's even a handout that you can provide to patients to track their preventive services, the vast majority of which are provided at no out-of-pocket cost to the patient.

Best Practice:

Maintain a database of patients who are "due" for preventive services; pull from that list when you experience a last-minute cancellation, or have an open schedule for a new provider. Contact the patient to inform him/her that he/she has a Medicare benefit available at no cost, and you'd love to schedule him/her an appointment! Patients appreciate the fact that you advised them about complimentary benefits of their insurance. This "best practice" idea also represents an opportunity to provide great care to your patients – and you can boost your practice's bottom line by converting a "wasted" slot to a fully-reimbursed one!

Charting Your Success in Employee Disciplinary Actions - Best Practices for Managing Staff Performance

No doubt employee discipline can be one of the most challenging aspects of human resource management. Perhaps this is due to the term “discipline” and the negative connotation associated with the details of disciplinary actions. Much of the stress related to managing staff disciplinary action surrounds the fear of being sued for wrongful termination or discrimination. The best defense against this concern is setting expectations for staff and consistently documenting discipline from the very beginning.

Management of staff expectations begins in the interview process as the applicant receives details of position performance standards in their job description. An employee focused orientation process reinforces those standards. The well-written employee handbook defines clear boundaries and provides illustrations of prohibited behaviors and rules of conduct. Additionally, the handbook should outline the details of performance management including disciplinary actions and employee grievance policies. With these tools in place, employee management and discipline become a constructive way to change behavior, attitude and job performance.

In dealing with the process of addressing performance and conduct issues the employer must understand the legal considerations of the disciplinary process. When terminated employees sue the employer for wrongful discharge, they must prove that they were denied “due process” which is what we typically refer to as “progressive discipline.” Due process is the employee’s right to be informed of unsatisfactory performance and to have the chance to both defend him/herself and show improvement before the employer chooses an adverse employment action (such as termination/discharge). Having policies in place makes these tasks easier and reduces slight missteps or errors.

Elements of due process are:

- Employees must understand the employer’s performance expectations and the consequences of not meeting them.
- Employers must be consistent in the application of company rules.
- Discipline must be appropriate for the situation or offense.
- Employees must be given the opportunity to respond during the disciplinary process.

- Employees must be given the opportunity to demonstrate acceptable behavior or performance improvement.

In dealing with due process, the employer should also remember:

- While the employer has the right to make changes to handbook or employee policies, employers must give employees advance notice of those changes with the effective date. This allows the employees to be ready for the change.
- Consistency in dealing with employee disciplinary action is important.
- Failure to provide due process in any termination action that does not involve progressive discipline or warning steps could result in legal complaints from employees.

A progressive disciplinary system gives structure to management of staff conduct and employs a number of steps that progress or lead to discharge if the conduct persists after multiple warnings. While employers may vary in the number of steps in their policies, most use between three to five. It is important for the employer to outline in the policy that serious infractions may result in skipping steps. Examples might include threatening a coworker with serious bodily injury or theft of company property.

Typical steps in a progressive disciplinary system:

1. **Verbal Warning** (with full documentation on file) - This warning is typically with open dialogue regarding what involves the nature of the infraction or where the employee has not met expectations of their position. Documentation includes the details or reasons for the counseling session, the date and time of the counseling and who was present during the discussion.
2. **First Written Warning** – This written warning outlines the problem or occurrence with full expectations for acceptable conduct. The tone is professional and objective. Often this puts the employee on probation for a specific period of time during which improvement is expected. The employee understands that any further incidences may warrant more serious action by the employer. Unlike the initial verbal counseling, the employee is asked to sign the document acknowledging the details and is given opportunity to respond in writing on the form - but is not required to do so.
3. **Second Written Warning –** This warning is in writing with discussion of expectations and consequences of non-compliance. The employee has opportunity to respond and sign the warning form. Often this warning may include a short suspension period of one to three days.
4. **Third or Final Warning –** This warning often includes a deadline for expected improvement and may include long suspension of at least one work week.
5. **Termination – Final result – If all other options have failed.**

Each step of progressive discipline should include a private meeting to discuss the warning, along with the employer's expectations, and allow the employee to respond. The progressive discipline system is the best protection against making mistakes that put the

practice at risk for wrongful discharge or discrimination claims. There are times when some infractions warrant skipping one or more of these steps. Examples might include physical altercation between employees or anything that puts patients or other employees at risk.

Termination Decisions

The employer should have a formal termination checklist. This useful tool assists the practice in gathering all the facts to make an informed decision. It includes interviews of those involved, investigation of previous issues with the employee, or other similar cases, review of the information gathered and a final meeting with the employee. Before making this final decision the employer should ensure that there are no concerns related to statutory considerations or protections related to discrimination, public policy protections related to whistle blowing or recent filing of workers compensation claims, or other issues such related to the National Labor Relations Act, Family Medical Leave Act or leave that falls under the Uniformed Services Employment and Reemployment Rights Act.

Legal counsel should always be consulted when unsure of action to be taken or when there are concerns related to claims of wrongful discharge or discrimination.

Document/Document/Document – It is a MUST!

Documentation of each step of the process is important to support decisions, particularly in the context of discipline that may result in termination. During the termination process the employer must document and support the decision for termination in detail. Even if the termination is not challenged by legal action or unemployment claims the documentation must be kept on file. This is also true in cases where the employment relationship is “at-will” (when an employee can be dismissed by an employer for any reason – so long as not discriminatory – without having to establish just cause and without warning). The documentation of all disciplinary actions must be maintained. Disciplinary forms can become a permanent record in the employee’s personnel file. Keeping these on file assists the human resource professional or management in determining appropriate actions necessary to address any future violation of policy or further performance management needs for the employee. If the practice chooses to remove such warnings from the files of current or even terminated employees, consult legal counsel before proceeding.

Day of Termination

The termination meeting should be short and direct. Use of an outline can be helpful to keep the meeting on track. A witness should always be present in the termination meeting. Reading the termination letter often makes the process easier on all involved. In the event that there are several reasons for the termination, ensure that all are listed and provided in the discussion. Consider preparing a formal termination checklist for gathering any company property that needs to be returned. If items to be returned are not on hand the employer can set a time to facilitate the exchange. Remember that it is impermissible to

withhold earned wages from the employee's last check for items that have not been returned. It is important to know and follow the state requirements for providing the notice of termination to the employee as well as his/her final paycheck. The final paycheck should include compensation for all hours worked as well as any accrued/unused time off that is outlined in the employee handbook as payable at the time of termination.

When in doubt – do the right thing!

Hardship Application - ACI Category

You can apply for a hardship exemption for the “Advancing Care Information” (ACI) category of the Quality Payment Program’s Merit-based Incentive Payment System. ACI counts for 25% of the composite performance score for eligible clinicians (ECs) in the government’s new payment program. The application, which is being accepted now, mirrors the exceptions historically available to “Meaningful Use” participants. If accepted, the ACI category will be reweighted to 0%, thus shifting your score to be formulated on the basis of Quality (85%) and Improvement Activities (15%) in 2017.

Applications are being accepted on a rolling basis for: insufficient internet connectivity, extreme and uncontrollable circumstances, and lack of control over the availability of Certified EHR Technology (CEHRT). The Centers for Medicare & Medicaid Services (CMS) specifically includes switching vendors in 2017 as an “extreme and uncontrollable circumstance.”

Regardless of the category, there is no supporting documentation required. However, CMS advises: “Clinicians and groups should retain documentation of their circumstances supporting their application for their own records in the event CMS requests data validation or audit.”

So-called “special-status” clinicians are automatically exempt and do not need to complete an application; these include hospital-based MIPS-ECs, non-patient-facing ECs and advanced practice providers.

If you’re not sure about participating in ACI – and thus, not sure if you should submit this application - note that CMS will score your ACI submission regardless. CMS reveals: “You may still report on the ACI performance category, and if you choose to report, your data will be scored. If you have a pending or approved hardship exception application and choose to report on the advancing care information measures, your hardship exception application will be dismissed.” Therefore, there’s no downside to submitting an application.

Applications are being accepted for practices, as well as individual providers. Once submitted, you will receive a confirmation via email, and whether the application is pending, approved, or dismissed.

Click here for a link to the application. For the hardship-exception website, please visit this page.

Know in Advance What a Patient Wants You to Do When They Can't Tell You

As the patient population ages, the likelihood of encountering a patient unable to make decisions regarding his or her care will increase. Unexpected and emergency situations however can obviously affect a patient at any age, rendering the patient unable to make care decisions for themselves.

Whether treating a geriatric or a mature pediatric patient, providers should be knowledgeable on steps that patients should take to communicate their desires regarding care in the event they become unable to make their own decisions about their care. Providers should also assess procedures within their practice regarding how patients' desires for care are communicated and handled. In many situations when these desires need to be known, little time is available for figuring out whether or not the patient has made healthcare plans known in advance and, if so, definitively determining what those desires are.

Adult patients and emancipated minors who can make healthcare decisions on their own should be encouraged to create advanced directives. Legal documents memorializing a patient's desires may go by various names, such as living will, advance care plan, medical power of attorney, or appointment of healthcare agent. Regardless of the form of the document, at a minimum, an advanced directive should contain at least two pieces of information: (1) wishes for levels of medical treatment (CPR, artificial life support, tube feeding, etc.) relative to qualities of life deemed as unacceptable (permanent unconscious state, end stage illness, etc.); and (2) the appointment of an individual, preferably with the identification of an alternate or successor individual, to make healthcare decisions on behalf of the individual in the event of incapacitation. Other items such as organ disposition, burial preferences, and care directions can also be provided in an advanced directive.

While requirements for executing advanced directive documents vary from state to state, in addition to being signed by the individual, the documents also typically must be witnessed by two other competent adults or be notarized. Many states have a form available on medical or bar association websites or on state agency sites. In Tennessee, a number of elements of different forms have been combined into one model Advance Directive for Health Care form adopted by the Board for Licensing Health Care Facilities effective May 9, 2017 and is available online. In using a model form however, it is important to confirm

that it conforms to the latest laws and regulations in the state.

Outside of a hospital or long-term care setting, advanced directives also play an important role in healthcare. Providers should encourage patients to have advance directives in place, even in an office practice setting. There are a number of clinical scenarios that may unfortunately arise implicating a need for an advanced directive.

While it is essential to rapidly identify a patient's code status, it is just as important to determine whether a patient has provided your practice with an advanced directive, which can provide more nuanced information than simply to resuscitate or not. Additionally, from a primary care office perspective, a hospital or other facility may contact the patient's primary care provider if the hospital is unable to locate information about a patient's advanced directive.

Your practice should have a written procedure in place documenting the system for receiving, maintaining, and identifying advanced directives, as well as incorporating any changes to a patient's advanced directive. The system should be established in a way that a definitive determination can quickly be made whether or not a patient has provided the practice with an advanced directive. In the chaos that often accompanies serious adverse occurrences, where a patient's wishes stated in an advance directive may unfortunately and suddenly become relevant, providers should be familiar how to ascertain whether the patient has executed an advanced directive regarding his or her care. Otherwise, very serious ethical and legal dilemmas may arise.

One way to determine a patient's advanced directive status is to request such information on a new patient registration form. If a patient has executed an advanced directive document, the practice needs to determine whether the patient has provided a copy to the office. If the patient has not provided the document, the practice should state the obvious to the patient that, without the advanced directive, the patient's wishes are unknown and the document should be provided as soon as possible. Inquiries regarding a patient's advance directive status can be made at regular intervals, such as when an existing patient is asked to verify and update data such as address and insurance information.

Advanced directives provide a way for patients to express their wishes regarding healthcare in very difficult and in some cases, unforeseen circumstances. When thoughtfully executed, in consultation with their family and physician, advanced directives can spare patients, their families, and their healthcare providers the often anguish-filled process of determining the best course for a patient when the individual has become incapacitated. It is incumbent upon providers who receive advanced directives to honor those patients' wishes. Practices should have the proper procedures in place to ensure these wishes, when made known by a patient, are identified and fulfilled.

2018 Penalties: PQRS and VBPM Informal Review Available Through December 1

On September 18, 2017, the Centers for Medicare & Medicaid Services (CMS) released the feedback reports for the Physician Quality Reporting System (PQRS) and the Value-based Payment Modifier (VBPM or VM). Both programs concluded at the conclusion of 2016, however, the impact on reimbursement continues through December 31, 2018.

For those who were not successful at 2016 reporting, PQRS will apply a 2 percent reduction to all Part B covered professional services under the Medicare Fee Schedule for the calendar year of 2018. The Value-based Payment Modifier adds another possible 4 percent reduction to reimbursement, based on 2016 participation. (Physicians in "small" practices of 1 to 9 professionals are capped at a 2 percent penalty.) Finally, physicians may see a third adjustment of 3 percent if they were not successful at participating in the EHR Incentive Program, often referred to as "Meaningful Use," in 2016. These three programs equate to a possible 9 percent reduction in Medicare payments for the entire year of 2018.

There is an opportunity to not only gain knowledge about these potential downward adjustments, but also to possibly reverse them. Upon the release of the feedback reports, CMS opened its informal **review period through December 1, 2017, 8:00 p.m. EST.**

The first step is to access a provider's PQRS and VBPM feedback report. CMS released reference guides at the following links to assist in obtaining these reports: for the PQRS program **and** the VBPM program**. In addition to accessing these reports,** CMS pledged to mail letters notifying individual physicians, advanced practice providers and medical practices, which did not meet the requirements. Obtaining the reports is vital: although there are some who never even attempted to participate, there are many who discover that they are being penalized despite the perception that they shouldn't be.

If CMS incorrectly evaluated a provider's participation, it's time to move to the second step. December 1 is the deadline to file an informal review to determine if there was an error in the reporting process or calculation. There are actually two informal reviews – one for the PQRS program, and the other for the VBPM. According to CMS, "An informal review may be requested if the feedback report reveals that the individual EP [eligible professional] or PQRS group practice disagrees with the analysis of satisfactory reporting to avoid a future payment adjustment… Please note that the informal review decision will be final, and there will be no further review." If the feedback reports for PQRS and VBPM

reveal successful participation, there is no need to initiate these reviews.

There is no such appeal for the EHR Incentive System, as the deadline has passed.

Don't drag your feet on getting started. Obtaining reports – and filing the appeals – will take time. Half the battle is simply obtaining the information, and getting on to the platform to transmit the application for the review. CMS' QualityNet portal is the gateway for these programs, and related documentation. Access hinges on your so-called "Enterprise Identity Management" (EIDM) – in essence, your user name and password to log in to your account. In addition to challenges in obtaining the EIDM, recognize the CMS temporarily disables account access every 60 days, a purported requirement of CMS' security policy. So, if you haven't accessed the portal in the past two months, be prepared to experience delays in logging in. And, if you haven't ever accessed your QualityNet account, be prepared to follow instructions closely. Here's a link to more information about the EIDM, but you may want to call the help desk at 1-866-288-8912; it's open from 8:00 a.m. to 8:00 p.m. EST Monday through Friday. Last fall during the same process, callers reported on-hold times of several hours, so be sure to have a speaker phone on hand. You can also try to reach them via email at qnetsupport@hcqis.org.

Avoid the last-minute panic; determine the status of any 2018 penalties today. If you feel they are being applied unfairly, take the opportunity to submit an appeal to hopefully have them reversed.

How to Submit an Informal Review:

For the Value-based Payment Modifier

For the Physician Quality Reporting System