Discontinuity of Care: Two Physicians, One Practice and One Patient's Tragedy

By Kathleen W. Smith, JD

“Continuity of care.” We often think about this concept involving physicians in different specialties or groups, such as the doctor who treats the patient after us or the doctor who referred the patient to us. However, when stripped down, the concept of “continuity of care” addresses any situation when multiple providers, whether inside or outside a practice, treat one patient for the same or related medical issue. Like puzzle pieces, the information from each provider needs to join together so that all relevant information for the ongoing medical issue is continuously available to all treating providers. If those puzzle pieces of information never join, then it may just be that the key piece of information falls through the cracks.

Like many toddlers, 18-month-old Caroline Jones* was in and out of her pediatrician’s office with a number of common pediatric illnesses. As is customary in pediatric practices, she saw several of the practice’s physicians throughout her numerous appointments. Caroline had recently been struggling with eczema and contact dermatitis, but the condition was just getting worse. Topical creams did not provide enough relief, and, during her July 26th appointment with Dr. Carpenter, her mother reported that Caroline had been scratching the eczema patches. Dr. Carpenter diagnosed Caroline with impetigo and prescribed a course of Bactrim for 10 days.

Mother brought Caroline back to see Dr. Carpenter on August 3rd, complaining of fever, some transient episodes of disorientation, and the worsening appearance of the rash on her daughter’s face. Mother also informed Dr. Carpenter that Caroline had recently been bitten by a tick. Dr. Carpenter examined Caroline and discovered otitis media in the right ear. He described her face as having annular patches on the cheek. Tinea corporis was felt to be the cause of the rash on Caroline’s face and an antibiotic was prescribed for her ear infection.

Caroline’s mother brought her daughter back to the office the following morning and saw Dr. Carpenter’s partner, Dr. Reynolds. Mother reported that Caroline had a high fever overnight and a “splotchy” face that morning. During the August 4thappointment, Dr. Reynolds described the rash as maculopapular. He also saw the right otitis media. Dr. Reynolds suspected Caroline was experiencing an allergic reaction to the antibiotic Dr. Carpenter prescribed the day before, so he substituted another antibiotic and counseled the mother that it would take one to two days to see clinical improvement in the allergic reaction. Dr. Reynolds did not follow up on the mother’s prior report of tick bite because

he was not aware of it. Dr. Reynolds later admitted that he did not read Dr. Carpenter's note of the prior day's appointment.

Twice that evening, Caroline's mother called the practice reporting that her daughter's fever persisted and the rash remained unchanged. During the second phone call, an appointment was made for the next day. Instead, the mother ended up taking Caroline to another pediatric practice and never returned to see Dr. Carpenter or Dr. Reynolds. Tragically, Caroline was diagnosed with ehrlichiosis four days later, dying from the infection two days after the diagnosis was made. Her mother subsequently filed a lawsuit against Dr. Carpenter, Dr. Reynolds, and their practice. The case was tried, and the jury awarded Caroline's mother a substantial verdict.

Although it was not recognized at the time, Caroline's mother gave Dr. Carpenter the key piece of information necessary to solve Caroline's impending medical crisis during the August 3rd appointment. Then, when Caroline returned the next day with worsening symptoms, Dr. Reynolds did not read the note of the prior day's office visit and never knew to include the history of recent tick bite with the information that he used when treating Caroline.

It is unknown whether ehrlichiosis would have been diagnosed earlier if Dr. Reynolds knew that the mother told Dr. Carpenter about the tick bite. However, if Dr. Reynolds had read his partner's note, the lawsuit would have been imminently more defensible. This is a simple, common sense practice point: to ensure the continuity of the patient's care, the provider should review the documentation discussing the patient's recent, relevant care. It is often this kind of simple task, when not performed by a defendant-doctor, that a jury cannot understand or forgive. In this case, Caroline's mother reported the tick bite only to Dr. Carpenter, and did not repeat the report to Dr. Reynolds. Perhaps she believed that, since she had already reported it to one doctor, she did not need to advise any subsequent provider. It is easy for a jury, comprised of lay people who are patients themselves, to understand why a plaintiff attorney blames a defendant-doctor for neglecting to perform such a simple task – and to agree.

As a footnote, when the mother transferred Caroline's care to another practice, she unwittingly caused the second disruption in the continuity of her daughter's care. The new pediatrician was charged with trying to solve the mystery of Caroline's illness after being thrust into the middle of its course. The mother did not repeat the history of tick bite to the new provider until August 8th. By that time, the infection had progressed past the point where Caroline could be saved. An abrupt transfer of care can result in crucial information never reaching the new provider who is starting from the beginning with a patient who may not have much time left – and this is a lesson for the patient in all of us.

* Names of patients and physicians have been changed

Coping with "Difficult" Coworkers

By Stephen A. Dickens, JD, FACMPE

“The staff are not getting along” is a cry for help I frequently hear from physicians and practice executives. Staff relationships can be one of the most time consuming and mentally draining aspects of a manager’s or supervisor’s day. Staff who find it difficult to work with one another not only influence the culture of the practice, but their failure to communicate effectively can lead to errors and adverse patient outcomes. When I am called into a practice and probe deeper into the issues, the comments from both sides are usually the same. They usually go something like this…

- “She is difficult to work with.”
- “He doesn’t listen to me.”
- “She is difficult to talk to.”
- “He doesn’t like me.”

Each side finds the other equally “difficult.” The reality is the “difficult” is often just “different.”

Very few employees set out to alienate their coworkers and be purposely difficult. Those individuals have an entirely different set of issues. Most people want to do a good job. The problem is that we all approach situations differently. Some of us are task focused; meaning that getting the job done is the most important thing. They work methodically from a checklist until it is complete. There is no chitchat until the work is done. Others are people focused; meaning relationships, people and feelings come first. For those individuals, making the patient feel welcome and cared for is more important than collecting the details needed for accurate billing and documentation. They view those things as tasks that can be completed after the emotional needs are met.

Clearly, both sides of the equation are important. Without efficient and timely billing processes and positive patient experiences, a practice cannot be successful in today’s environment. It is easy to see how conflict ensues when each side views the others’ priorities as misplaced. Add into the equation how we each communicate. Some are strongly introverted and private. They need peace and quiet to work effectively. Others are extroverts who thrive on giving and getting attention amidst all the chaos that occurs in a busy medical practice. They need the excitement to keep them going. The key to effective relationships is understanding how you work and communicate while respecting that others may have different styles and needs.

A practice experiencing these issues called me recently. After speaking with the practice executive, I was able to recommend a presentation that focused on these different styles.

With a simple personality assessment, the staff quickly realized where the issues were. They were simply different, not difficult. Talking about the positives and challenges of each style, everyone quickly realized some of the stereotypes fit. Acknowledging that it takes a variety of personalities, skills and styles to run an office effectively, the mood lightened as they viewed each other in a new light. A sense of appreciation for one another's skills emerged. Once they understood the need to adapt their communication based on the listener, it not only improved their communication skills with one another, but also with their patients. Empathy and collaboration replaced the suspicion and discord, which had previously prevented them from becoming the most effective team needed to thrive in today's evolving healthcare environment.

SVMIC's Medical Practice Services division can assist practices facing challenges of this type. ContactSVMIC@svmic.com or call 800.342.2239 for assistance.

Tips to Prevent Denied Claims

By Elizabeth Woodcock, MBA, FACMPE, CPC

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. Let's review five strategies to address denial prevention.

1. **Get to the root of the problem**. Why are your 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; look for 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 not uncommonly 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 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 commonly received denials 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.

Ten Common CARCs:

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 a 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

Meaningful Use: Avoiding the 3% Penalty in 2018

By Elizabeth Woodcock, MBA, FACMPE, CPC

If you did not report meaningful use in 2016 – or failed to do so successfully – the government will impose a 3% penalty in 2018 on all Medicare payments. Now is the opportune time to review government applications to try to get an exemption for that penalty. Just posted on March 7, the applications focus on avoiding the EHR Incentive Program 3% penalty.

The first application is the annual hardship form. The following categories are available to physicians and other eligible professionals for the hardship declaration:

1. Insufficient Internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of Certified EHR Technology
4. Lack of face-to-face patient interaction

Under the second category, there is a section titled – "2.2d. EHR Certification/Vendor Issues." By far the most comprehensive category, physicians can declare an exemption based on the fact that they "…faced extreme and uncontrollable circumstances in the form of issues with the certification of the EHR product or products such as delays or decertification, issues with the implementation of the CEHRT such as switching products, or issues related to insufficient time to make changes to the CEHRT to meet CMS regulatory requirements for reporting in 2016."

The only requirement is a signature of attestation; the form allows the opportunity to submit a single application on behalf of all eligible professionals in your practice.

The application is due July 1, 2017.

Hardship Form

If you've never participated in the EHR Incentive Program, you have another option to avoid the 2018 penalties. This one comes with some strings, however. In addition to never having been successful at "meaningful use" reporting, eligible professionals must declare their intention to participate in the Advancing Care Information (ACI) category of the new Merit-based Incentive Program (MIPS). Here's the attestation statement from the application:

New Eligible Professional Transitioning to MIPS 2017. The EP has never participated in the EHR Incentive Program prior to 2017 and is transitioning to MIPS and will report on the

*advancing care information performance category in 2017. I, (*print name of Eligible Professional*), am requesting this Medicare EHR Incentive Program one time significant Hardship Exception and attest to and can demonstrate (the practice indicated on the Application), based on my/our particular circumstances, that I/we are demonstrating meaningful use for the first time in 2017 under the EHR Incentive Program and also are/will report on measures specified for the advancing care information performance category under the MIPS in 2017 as this would result in a significant hardship.**

The asterisk indicates the requirement to maintain documentation on this intention for six years.

Because ACI is not required to avoid the 4% penalty associated with MIPS, this application carries a more significant burden than simply applying for a hardship. (See the February issue of the Sentinel for 2017 MIPS program requirements.)

However, the deadline is not until October 1, 2017. Similar to the hardship application, you can apply on behalf of all of your eligible professionals.

Transitioning to MIPS Hardship Form

For those of you who submitted applications in the past, a gentle reminder that the government grants exceptions for one year at a time. Even if you've successfully declared a hardship in the past, you'll need to do so again this year. Don't wait until the last minute; determine which form is appropriate for your situation – and submit it!

It's Not Easy to Say Goodbye: Properly Discharging a Patient from Your Practice

By Justin Joy, JD, CIPP

Once a physician has established a professional relationship with a patient, the physician has an on-going legal duty to care for that patient. The expected length of this relationship varies based the type of care being provided. If a patient is referred to a surgeon for a single procedure, the professional relationship between the surgeon and the patient typically ends when the patient has fully recovered from the surgery. In contrast, in the family medicine context, the professional relationship between the primary care physician and the patient may last from cradle to grave.

As long as a professional relationship exists between a physician and a patient, there is a legal duty on the physician not to abandon the patient. Some situations arise, however, when it is in the physician's best interest to terminate a relationship with a patient before the expected end of the relationship. Obviously, missing multiple appointments in a row, persistently disagreeing with their physician's advice, disregarding care instructions outright, or even becoming confrontational with the physician or his/her staff, can be a sign of a problematic patient-physician relationship.

Breaking up is hard to do, and terminating a relationship with a patient in these circumstances is not without legal risks. Properly discharging a patient from a practice, however, is sometimes a necessary step. Despite the risk, there can be benefits to both the physician and the patient. In instances where there has been a breakdown in communication between a patient and a physician, it can allow the patient to seek care from another physician with whom the patient may be more compatible.

Improperly abandoning a patient can result in serious consequences. In today's customer-review driven world, a patient believing that he/she has been improperly abandoned can quickly pick up the social media megaphone and create a significant reputational problem for a physician. Improperly abandoning a patient that results in an adverse health event for the patient can give rise to serious legal liability.

Given the serious consequences of abandoning a patient, the decision to discharge a patient should be done with an articulable, and preferably well-documented, reason. Some of these reasons include: repeated missed appointments after appropriate attempts to contact the patient have been made; complete disregard for a treatment plan; and

violations of office policies. The better your documentation of these types of events, especially when they are not isolated occurrences, the better your defense will be that the discharge of the patient was not only justified, but necessary.

Notice of your decision to terminate your relationship with the patient should be given in the form of a letter, sent by both certified mail, return receipt requested, and regular mail with a copy of the letter placed in the patient's chart. The letter should be clear and concise, stating, unless inappropriate to do so, in general terms the reason for terminating the relationship and the effective date of the termination, typically 30 days from the date of the letter. The letter should also explain that medication refills will no longer be provided after the effective date of the termination, and it is the patient's responsibility to seek necessary follow-up care from another physician. Instead of providing a specific referral, patients should be referred to a local medical association or online directory of physicians in the area. The letter should also include a clear direction to seek care from another physician promptly but, in the interim, until the effective date of the termination, care will continue to be provided in true emergency situations. The letter needs to contain instructions advising the patient how to obtain a copy of his/her medical record from your office. The letter should not contain legalese or difficult terms but should be written in a manner that would not provide grounds for embarrassment for your practice, or worse, if the letter is posted online by the patient.

Even when circumstances become difficult—including if the patient stops paying for your services—there are some situations where a patient should not discharged. These include: patients in an acute phase of treatment; lack of other physicians, particularly specialists, to whom the patient's care can be safely transferred; and third-trimester pregnancies or complicated second-trimester pregnancies.

Once a patient has been discharged from the practice, the scheduling system should be flagged and the staff informed accordingly so the patient is not permitted to schedule another appointment with the practice. This can be difficult in a multi-specialty, multi-office group but steps should be taken to avoid inadvertently re-establishing the relationship with a discharged patient.

Other factors to keep in mind include non-retaliation, non-discrimination and payer considerations. You should check with the patient's health insurance company, and in particular any prepaid health plans, about any guidelines or provisions on discharging a plan member before the decision is made to terminate the patient. A patient cannot be discharged for a discriminatory reason. Relatedly, a patient should never be discharged in retaliation for making a complaint under the Section 1557 regulations, other anti-discrimination laws, or HIPAA. Doing so could result in regulatory violations.

On the proactive front, while all possible scenarios for the justification to "fire" a patient cannot be anticipated, some of the more common reasons—failure to pay, missed appointments, and disruptive or deceptive behavior—may be addressed in a patient discharge policy. While each situation is unique and the decision to discharge a patient must be made thoughtfully on a case-by-case basis, having a documented policy in place

helps your practice handle these difficult situations more consistently. Additionally, if your practice provides notice of the grounds in the policy potentially leading to termination, it should reduce a claim of surprise or disbelief by a patient when he or she is discharged from the practice.

Hopefully, the vast majority of the relationships with patients are positive, if not harmonious. Circumstances may arise in your practice, however, when it becomes necessary to terminate a patient relationship. Discharging a patient carries significant risk but properly terminating a patient-physician relationship can certainly reduce the risk.

Sample termination letters are available here.

Risk Pearls: April 2017

By Julie Loomis, RN, JD

Spring has sprung, which means spring cleaning for many of us. It may also be a good time to retool your office tracking procedures, as diagnostic error accounts for one-third of SVMIC's paid claims. Tracking system failures are a primary factor in diagnostic error. Maintaining a system within each office site for tracking lab and diagnostic test results, referred patients, hospital discharges and missed appointments is essential to avoiding delays in diagnosis and/or treatment. A patient may fall through the cracks if your office fails to act upon an abnormal test result or a missed appointment. Review your tracking procedures to ensure your method best fits your practice. The type of system chosen will depend largely on the nature of the practice and your choice of medical records (paper or EHR). Tracking procedures should be simple, organized, and consistently used by all staff and providers in the practice. Staff should be trained and accountable for accurately maintaining the system and alerting providers when expected results are not received. Remember, tracking is only part of the equation for proper procedure management. Appropriate patient communication and documentation is also necessary for the prevention of missed or delayed diagnoses.

An Analysis of Nephrology Closed Claims

By Shelly Weatherly, JD

As the graph below illustrates, medication errors was a common theme in SVMIC paid nephrology claims over the past 5 years. Additionally, failure to diagnose was a primary allegation asserted in the claims. Most typically, the diagnostic errors were not the result of a lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of poor documentation, communication breakdowns and poorly designed or ineffective systems.

MEDICATION ISSUES: Wrong dose and contraindicated medications were the main issues noted in the reviewed claims. A classic example of a wrong dose event is illustrated in the case of a physician who intended to order 2 mEq potassium chloride to peritoneal dialysis fluid, but mistakenly wrote 20 mEq. The patient arrested and died. To compound the problem, the physician went back after the event, crossed out the "20" and replaced it with a "2". Contraindicated medications were a problem in a case where the physician failed to discontinue Heparin in the face of Heparin-induced thrombocytopenia, and in another case where there was a failure to discontinue Lovenox in a patient scheduled for an invasive biopsy on the kidney. In both cases, the patients suffered bleeding complications and died.

Image not found or type unknown

COMMUNICATION ISSUES: Effective communication is essential in establishing trust, building good patient rapport and helping to achieve treatment compliance. It is important to communicate information and instructions to patients in terms understandable to non-medically trained individuals. The majority of the cases involving physician to patient communication breakdowns involved the physician failing to provide clear information related to the risks or instructions associated with medications.

There were also communication breakdowns between providers in the reviewed cases. An example involved a patient hospitalized for angina and a subacute MI with congestive heart failure. Treatment included Lovenox and Digoxin. During the hospitalization, the patient was determined to have chronic renal insufficiency requiring acute hemodialysis. The Nephrologist failed to adjust the Lovenox dose, assuming the cardiologist would do so. The patient developed a thoracic hematoma and died.

DOCUMENTATION ISSUES: The importance of maintaining a well-documented medical record, from both a patient care and a risk management standpoint, cannot be overstated. As the graph above illustrates, documentation issues were a factor in 38% of claims paid

in Nephrology. The majority of these cases involved inadequate documentation. Most often, there was a failure to document completely the patient and/or family history, details of the physical exam, rationale for the diagnosis and treatment plan, patient education, and conversations with the patient and family regarding treatment recommendations.

SYSTEMS ISSUES: The failure to track and act on test results was a common problem in the cases involving systems issues. One case involved a hospitalized patient who was administered IV morphine following the onset of severe flank pain six hours post-renal biopsy. The on-call nephrologist ordered a CT scan and labs. The CT scan revealed a large perirenal hematoma. The on-call doctor did not receive notification of the CT scan results, nor went to the hospital to evaluate the patient. The next morning, the patient's hematocrit dropped significantly. The physician then reviewed the results of the CT scan and noted the hematoma. Transfusions and other measures were unsuccessful and the patient died. The failure of the on-call physician to follow up on the results of the tests he ordered and his delay in going in to evaluate a patient in clear distress caused problems for the defense that led to a settlement of the case.

LESSONS LEARNED:

- To help prevent medication errors: Update the medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits of, and alternatives to prescribed medications; closely monitor medications with a known toxic effect; train staff who are allowed to administer medications to adhere to the "Five Rights" (right patient, right drug, right dose, right route, right time) and appropriate injection techniques.

- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, alternatives, and expected outcome. Be careful not to educate above a patient's comprehension level. Be sure the details of all discussions with patients are documented in office records rather than relying on hospital consent forms, which are not procedure-specific and may not capture all details of a conversation.

- Communicate relevant patient information to the covering physician in a timely and clear manner, especially information on patients with anticipated problems.

- When other providers are involved in the care of a patient, make sure there is a clear understanding as to everyone's role and responsibility.

- Clearly communicate and document telephonic advice – use teach back to ensure the patient understands advice given.

- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief complaint or purpose for the visit; all relevant positive and negative clinical findings; your diagnosis or medical

impression; the decision-making process for the clearly defined treatment plan; and all relevant instructions and information given to the patient regarding the treatment plan.

- In order to ensure proper follow-up for patients who require a return office visit, schedule such patients before they leave the office or the hospital and provide a reminder card with date and time.
- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it is important enough to track and personally review.
- To promote continuity of care, implement a system to ensure abnormal test results receive proper follow-up.
- 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.
- Implement a tracking system for patients who miss or cancel scheduled appointments and have office staff contact the patient and reschedule the appointment in situations where the patient may suffer if there is a delay in treatment, or where ongoing monitoring of the treatment or medication is necessary.
