Successful Defense of Surgical Judgment

By Dan Himmelberg, JD

Mr. Gamgee1 was a 70 year-old male who was a smoker and slightly overweight. He had a history of back pain and of a skin cancer removed 20 years before. His hypertension had been treated over many years with various medications but was not well controlled. He presented to the Emergency Department early Thursday evening with right lower quadrant abdominal pain (which he reported as a 10 out of 10 on a pain scale), stating he had been experiencing this pain for a day. Mr. Gamgee complained of nausea, vomiting and insomnia the night before. He had a BP of 174/89, temperature of 98.9, pulse of 64 and respirations of 20. CBC test results showed his white blood count slightly elevated at 13.5. Blood chemistry labs showed an elevated BUN at 23 and elevated creatinine at 1.8. X-ray imaging showed a calcified aortic shadow suggesting an infrarenal aortic aneurysm which warranted follow-up evaluation. Mr. Gamgee was admitted for surgical evaluation.

Morphine helped the patient's pain, and a CT scan was performed. The surgeon, Dr. Whyte, reviewed the CT imaging himself and identified a large aortic aneurysm below the renal artery but saw no evidence of leakage of blood from the aneurysm. A radiology report the next day agreed with this interpretation. Dr. Whyte interpreted the CT imaging as not confirming an abnormality of the appendix but not ruling it out. The later radiology report did not mention the appendix. When Dr. Whyte evaluated Mr. Gamgee, his right lower quadrant was very tender at McBurney's point. There was little abdominal distension. He was able to palpate the aneurysm, and the patient did not report tenderness. Mr. Gamgee was not tachycardic.

Dr. Whyte recognized the surgical dilemma. The clinical symptoms were strongly suggestive of appendicitis, but the CT imaging did not show appendicitis. The CT imaging was thought to be up to 95% accurate in diagnosing appendicitis. Alternatively, the symptoms were not typical, but Dr. Whyte could not rule out that the aneurysm was causing them. Additionally, the patient was at increased surgical risk due to his high blood pressure and kidney concerns.

Dr. Whyte decided the best course was to perform a diagnostic laparoscopy then let his findings guide the surgical course. If it showed any evidence of blood tinged fluid then he would proceed with emergency repair of the aneurysm. If it did not, then he would evaluate the appendix and otherwise try to optimize the patient for later surgical repair of the aneurysm. Mrs. Gamgee signed the surgical consent for her husband. In the surgery, Dr. Whyte saw no evidence of leakage from the aneurysm. He described the appendix as

appearing “a little inflamed”. Because it did not appear completely normal and Mr. Gamgee had strong clinical symptoms, Dr. Whyte removed the appendix.

After surgery, Mr. Gamgee was admitted to the ICU to try to improve his blood pressure and kidney function. Dr. Whyte’s plan was for an arteriogram to take place the following Monday to further assess the aneurysm. The next day, Friday, cardiologist Dr. Took assessed the patient as high risk for further surgery and recommended proceeding with caution. Mr. Gamgee was in no distress and no longer had nausea or vomiting.

Dr. Whyte briefed his partner, Dr. Brandybuck, who was covering for him over the weekend. Mr. Gamgee appeared to improve on Saturday. Dr. Brandybuck and a radiologist reviewed the CT scan from Friday and agreed that it did not show any signs of leakage from the aneurysm. A preliminary pathology report stated the appendix appeared to be normal. Mr. Gamgee appeared stable and improved through the day on Sunday. At 22:40 Sunday evening, he complained of some right flank pain. At 22:43 Mr. Gamgee complained of intense sharp back pain, his eyes rolled back, and he arrested. Resuscitative efforts were not successful, and Mr. Gamgee was pronounced dead at 23:05. The record of death noted the immediate cause of death as “cardiopulmonary arrest” and did not reference a ruptured aneurysm. No autopsy was conducted. Dr. Whyte prepared the death certificate and listed “ruptured abdominal aneurysm” as the cause of death.

Ten months after the death, Mrs. Gamgee filed suit against Dr. Whyte. The litigation advanced, and her experts opined that Dr. Whyte should have ruled out appendicitis. They stated that the CT results showed no problems with the appendix and given Mr. Gamgee’s pain complaint of 10 out of 10, there should have been a high level of suspicion that the appendix was not the cause. These experts testified that the aneurysm was the true concern that should have been dealt with urgently. They conceded that the patient’s blood pressure and kidney function needed to be dealt with but they alleged that this could have been done within a day. They noted how well the patient was doing the day after the appendectomy. The plaintiff’s experts opined that the aneurysm could have been dealt with that day if Dr. Whyte had not imprudently performed the appendectomy. If the aneurysm had been treated (either by stenting or with a bypass) then the rupture and death would have been avoided.

Dr. Whyte defended his care and had supportive experts. Fortunately, Dr. Whyte’s surgical decision-making was outlined in the records which aided his defense significantly – especially when trying to convey what he was thinking at the time he was treating the patient (without the benefit of 20/20 hindsight). Dr. Whyte’s testimony, in his deposition and a trial, needed to be credible and convincing in order to fully explain his actions and thought process. Even though Dr. Whyte had served as a testifying expert witness in the defense of other surgeons and was generally familiar with the process, he took the extra step of working with a witness preparation consultant prior to his trial testimony. Explaining his care as a defendant required a different mind-set and perspective than he had needed an expert witness. He had to show his care and concern for Mr. Gamgee as

much as his actual surgical expertise and decision-making based on the information he had at the time. Fortunately, the jury found that Dr. Whyte used reasonable surgical judgment and returned a defense verdict on his behalf. The Court entered a Judgment for Dr. Whyte and dismissed the lawsuit. This case was likely won at trial due to Dr. Whyte's thorough documentation in the patient's record at the time of treatment and then his time and effort in working with his defense team after the suit was filed.

[1]The names of the patient and physicians have been changed.

SVMIC's New Education Center

By Meghan Clark

You may recall completing the 2015 Policyholder Survey we conducted in the spring of 2015 that assessed your opinions on a variety of topics. The results of the survey provided a clear mandate for SVMIC to raise the bar in our online educational offerings for physicians and staff. To satisfy this mandate, a company-wide team spent 2016 working on a solution.

For many years, SVMIC has had excellent processes for presenting live seminars, but the ability to offer advanced options for online content required the selection and deployment of a new software system. This month SVMIC launched a new platform, the SVMIC Education Center, which offers more variety in risk education, easier self-service, and a larger number of online course options. In addition to these benefits, we also are happy to provide a better overall experience from registration to self-tracking for all SVMIC educational opportunities.

Web-based education can be highly beneficial for the learner, as it offers the opportunity for self-paced learning with the added benefit of self-management. It can be equally beneficial for the educator, as it opens up options for more creative delivery methods and more precise tracking. The SVMIC Education Center is just the beginning of our focus on web-based learning, as you will now begin to see growth in the number of online courses and topics offered, as well as experience a more cohesive and expansive education experience.

Policyholders can now easily access – all in one place - SVMIC's educational offerings, transcripts of courses completed, courses pending completion, and all completion certificates for 2017 going forward. A substantial increase in course offerings and a broader variety of course topics are now available. Courses can be easily located with the use of a new course catalog with course format, credit eligibility, and even location filters for our live seminars. Courses that pique interest can be bookmarked for later registration, and online course progression will be saved for completion at the learner's pace.

The ability to access these courses requires nothing more than an SVMIC E-Access online account; that process remains the same. Once an account is validated, the policyholder can reach the new Education Center directly from SVMIC's website, www.svmic.com. Brief video tutorials are available on the Education Center homepage and on the course landing pages. Our goal is to make this transition as simple as possible for our policyholders, and to provide our learners with extra benefits that save time, make the experience more enjoyable, increase options, and help manage educational documents such as transcripts

and certificates.

SVMIC also continues to offer CME courses online and in booklet form; however, these courses are no longer provided by a third party. Because these are now written and managed internally, we can provide better customer service to our policyholders and a greater breadth of CME-eligible course content.

In the past year, SVMIC has added the following courses:

- Achieving Service Excellence
- New and improved HIPAA for the Medical Office
- New and improved OSHA Training
- Liability Exposure in Anesthesiology
- Liability Exposure in Radiology
- Patient Satisfaction Survey and Tools
- Communications
- Telephone Etiquette
- Marketing
- Effective Documentation in the Electronic Health Record
- Documenting Difficult Situations in the Electronic Health Record
- Tracking Labs and Diagnostics
- Risks to Avoid when Documenting with the Electronic Health Record
- Give Em' the Pickle Video

In 2017, SVMIC created and added two new online CME courses:

- Risk Reduction in the Medical Office
- Working Effectively with Advanced Practice Providers

As always, SVMIC will offer live seminars in several locations from March thru October. The only thing that has changed about live seminars is that policyholders with an online E-Access account can log in and download their certificates (30 days after seminar completion), as well as store and maintain those certificates, in the Education Center.

As the year progresses, SVMIC looks forward to receiving feedback from learners using our new Education Center. Our team is dedicated to tailoring this new and exciting online educational experience optimized to fit our policyholders' needs. The ultimate goal is to provide a well-rounded array of educational topics to the policyholder, accompanied by an enjoyable and easy-to-use process.

Meaningful Use: 2016 Reporting & Potential Relief from Penalties

By Elizabeth Woodcock, MBA, FACMPE, CPC

Although 2016 has come to a close, the time is now to report for the Electronic Health Record (EHR) Incentive Program. As confirmed in November, the reporting period is any 90 consecutive days during 2016. The criteria were drastically reduced from prior years, so it may be an opportune time to report even if you weren't as diligent in monitoring your compliance this year. The attestation system is open from January 3 to February 28, 2017; to report, click here.

What's on the line? A negative 3% payment adjustment applied to all Medicare reimbursement in 2018. The 2016 reporting year is the final year of the program, although the federal government is migrating to the Merit-based Incentive Payment System (MIPS), which includes a category that mirrors the current Meaningful Use requirements, that of Advancing Care Information.

More and more physicians are experiencing penalties related to the failure to participate in the EHR Incentive Program. To determine if your payments are being adjusted, look at your Medicare remittances. If you see the code, CO237 – Contractual Obligation-Legislative Penalty- alongside the remark, N700 EHR Incentive Program, the adjustment is being applied to you. Click here for more information about the adjustment.

Successful participation is the best way to avoid the penalties; however, there are two options available to potentially halt them – and thus, save you thousands of dollars.

First, let's review the opportunity to reverse the adjustment that is currently being imposed. The Centers for Medicare & Medicaid Services recently released the 2017 EP Reconsideration Application, indicating that the application was appropriate for physicians who "received a letter from CMS stating that "you are subject to the 2017 Medicare EHR payment adjustment and feel that this payment adjustment is in error."

If you are being penalized in 2017, a reconsideration may be in order. A declaration is available for the following reasons, noting that you can choose more than one:

- New Eligible Professional (EP)
- Hospital-based EP (90% or more of services were performed in the inpatient setting or emergency department)
- PECOS-Related Issue (delay in change of ownership or revalidation)

- Specialty Exemption (05-Anesthesiology, 22-Pathology, 30-Diagnostic Radiology, 36-Nuclear Medicine, 94- Interventional Radiology)
- Experienced a 2017 Hardship Issue
- EP was approved a 2017 Hardship or is exempt from the payment adjustment AND received the 2017 payment adjustment letter
- Certified Electronic Health Record Technology (CEHRT) Vendor Issues
- Meaningful use attestation issues for 2015
- Closure of Practice
- Ineligible Provider (e.g., Nurse Practitioner or Physician Assistant)

CMS requests a brief description of the reconsideration, offering a blank space on the application for you to document your reason(s). As is obvious from the generic verbiage – "Meaningful use attestation issues for 2015," and "CEHRT Vendor Issues," as examples, the application may offer the opportunity to be relieved of the penalties if you offer a compelling explanation. If you tried to participate, but encountered obstacles that prevented you from being successful, take the time to complete the documentation. You'll find the application available at this link. There is no downside to applying; the submission deadline is February 28, 2017.

Second, the 2018 penalty, which is based on the reporting year of 2016, may also be avoided. CMS, however, has not yet announced the details of who can apply or how the process will work. In the summary of the November 1, 2016 OPPS Final Rule, CMS states: "CMS is finalizing proposals that certain EPs, who are new participants in the EHR Incentive Program in 2017 and are transitioning to MIPS in 2017, can apply for a significant hardship exception from the 2018 payment adjustment…using a CMS developed hardship exception application process specific to this policy." The particulars have not yet been released, but this is good news for those who have not participated in the EHR Incentive Program in the past.*

Although the EHR Incentive Program has come to a close, its payment adjustments will linger until the conclusion of 2018. However, these options may offer relief from the potential penalties.

**Stay tuned, as we'll cover this new hardship exception process in an upcoming issue of the SVMIC Sentinel, after CMS releases the details.*

Patient Access & Charging for Medical Records

Providing patients with copies of their medical record is not a new concept for medical practices. However, processes in place for doing so may need some significant updates based on guidance issued by the U. S. Department of Health and Human Services (HHS) in 2016. In this guidance, which is based on 45 CFR § 164.524 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HHS reiterates the importance of providing individuals with timely access to their protected health information (PHI) in the form and format requested and, if a fee is imposed, it must be reasonable and cost-based. This guidance was issued in large part due to the number of complaints from patients who could not obtain timely access to their PHI or who could not afford the fees charged for copies.

Form, Format and Manner of Access

HIPAA requires covered entities (medical practices, hospitals, health plans, etc.) to provide individuals access to their PHI in whatever form and format they chose, if the covered entity can produce a copy in that specific form and format. This means that practices must be prepared to handle requests for access in a number of ways, such as saving files on a CD, emailing PHI to the patient or simply providing the patient with a paper copy. The point made in the guidance is that covered entities must accommodate the patient's request unless the PHI cannot be produced readily in the requested format.

According to HIPAA rules, covered entities that maintain PHI electronically must be able to provide an electronic copy at the request of the patient. For practices that maintain PHI in paper charts, there is a requirement to provide an electronic copy, at the patient's request, if it is readily producible in electronic form. For example, if a patient requests that the practice scan their lab results and save them as a PDF on a USB drive, the practice would be required to do so if they have that ability. When an individual requests a paper copy of PHI maintained in either paper or electronic form, HHS expects the covered entity to provide a paper copy.

Requiring a Written Request, Verification, and Unreasonable Measures

Many practices have a written process for patients to request copies of records. HIPAA states that a covered entity may require an individual to make their request for access in writing, but HIPAA does not require a written request. HIPAA doesrequire covered entities to take reasonable steps to verify the identity of the individual making the request for access, but this can be done in a number of different ways. Verification may be done orally or in writing, in person, over the phone or through a patient portal.

The guidance states that the covered entity must not impose unreasonable measures on the individual that could create barriers or unreasonably delay access. For example, a practice may not require an individual who wants a copy of their PHI mailed to their home to physically come into the office to complete a medical records release and provide a photo ID. This would be considered an unreasonable measure and could result in potential penalties. In order to reduce the risk of imposing unreasonable measures, covered entities are encouraged to have multiple options for patients to obtain access to PHI.

Timeliness of Access

Timeliness of providing access is also important. Under HIPAA, the covered entity must provide access no later than 30 calendar days from the date of the request. However, HHS prefers that access be provided as soon as possible. If state law requires a shorter period to provide access, then that time frame must be followed.

Charging for Copies

One of the major points of clarification from HHS is the limitation on fees that can be charged for PHI provided directly to the patient or directed to a third party by the patient. HIPAA states that a reasonable, cost-based fee may be charged for providing individuals a copy of their PHI. Reasonable, cost-based fees may include only:

- Labor for creating and delivering the electronic or paper copy
- Supplies for creating the copy (e.g., paper, toner, CD or USB)
- Postage, if the patient requests that the PHI be mailed

Labor does not include costs associated with reviewing the request for access, searching for and retrieving the PHI, or segregating or preparing the PHI to be copied. Even if state law allows a retrieval fee, it may not be included in the reasonable, cost-based fee to the patient.

Many medical practices, who choose to charge patients for copies of their PHI, have based fees on those allowed by state law, which are typically set at a per page rate. According to the guidance, most state authorized fees are higher than the reasonable, cost-based fees allowed by HIPAA and therefore may not be used.

HHS would prefer that covered entities provide patients with free access to their PHI, but if a covered entity chooses to charge patients for copies they are limited a reasonable, cost-based fee. Fees must be provided to patients in advance of their request for access. HHS

states that, in lieu of calculating the actual cost, a flat fee of $6.50 may be charged to patients for electronic copies of records maintained electronically. If this method is used, it is all-inclusive of labor, supplies and postage.

Third Party Access and Copies

Third parties that request PHI based on a signed authorization by the patient are not subject to the cost-based fee limitations and may be charged based on what state law allows. However, if the patient requests their information be sent directly to a third party, the fee limitations do apply. The patient will be responsible for paying for copies in this case, based on the reasonable, cost-based fee or flat fee rate. If a patient requests that their PHI be sent to a third party, the request must be made in writing and include the patient's signature, the name of the third party, and where the information should be sent (mailing address, email, fax number, etc.).

In order to ensure compliance with HIPAA and the patient's right to access PHI, practices are encouraged to review existing policies and procedures pertaining to access as well as the HHS guidance in its entirety. The guidance may be found here. For questions regarding patient rights to access and charging for copies of PHI, please contact Loretta Duncan at LorettaD@svmic.com.

Film-Based Imaging Reimbursement Cut (January 2017)

By Elizabeth Woodcock, MBA, FACMPE, CPC

If you rely on film-based imaging in your practice, Medicare reimbursement will change when you bill for an x-ray. Film-based imaging services billed globally, or when billing the technical component only, must be submitted with a modifier FX. The new modifier, required as of January 1, 2017, triggers a reduction of 20% to the technical reimbursement. No modifier is required if you have digital or computed radiology (CR). Note, however, that CR is slated for a similar reduction in payment beginning on January 1, 2018.

See CMS' article for more information on the new cut here.

Risk Pearls: January 2017

By Julie Loomis, RN, JD

The term “culture” in your medical practice shouldn’t only mean a lab test to identify microorganisms. Even if you’re not aware of it, there is an environmental culture within your practice that affects productivity, staff performance and patient safety. Culture is a system of shared values and beliefs that influence how people in the organization behave. Culture is dynamic, and maintaining a healthy culture requires nurturing. The new year is a good time to assess expectations and values; how the practice treats employees and patients; and establish new goals. Emphasis on people, innovation and the patient experience may enrich your practice’s culture and start the new year off right.

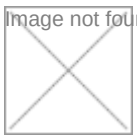
An Analysis of Pathology Closed Claims

By Carolyn Akland, MBA, RN, CPHQ, LNCC

A review of SVMIC pathology claims from 2007 – 2016, where a monetary loss was paid on behalf of an insured, reveals the top two diagnoses involved to be: Cervical Cancer and Hodgkin's Lymphoma.

The vast majority of the claims involved a misread, which resulted in cancer advancement and emotional/financial injury. In 38% of the claims, there were systems issues that coincided with the misread specimens, which contributed to the indefensibility of the claims. These "systems" issues occurred primarily in the pre-analytic phase but also in the analytic phase and most certainly complicated the defensibility of the medical malpractice lawsuit.

The types of Systems Issues are illustrated in the chart below:



Specimen Loss/Mix-ups accounted for 78% of the systems issues and included the collection and handling practices of the submitting physician by his/her staff; the processes within the lab to transport and receive the specimen; accessioning and slide identification. Mislabeling, misidentification, sorting, routing and pour-off (decanting) errors were involved in these steps, all of which can have profound consequences on patient safety.

Specimen contamination (floaters, carry-over artifacts and cross-contamination) accounted for 22% of the systems errors.

Often the dispute between who caused the mix-up (the surgeon's office, the hospital frozen section suite personnel, the couriers or the pathology lab) goes unresolved. It can seem like the only "fault" of the pathologist is that he/she was next on the sign out schedule when a "systems" mistake occurred. Having well-documented and consistently used processes for accessioning, handling specimens and identifying slides in the process of being read is essential to accurate and timely diagnosis as well as to the defense of a claim.

The following are some examples of the types of claims seen by SVMIC where the defense was complicated by systems issues:

Pre-analytical phase mix-ups:

Case #1: A 48-year-old with an elevated PSA underwent a prostate biopsy in his urologist's office. His father likewise underwent the same procedure that afternoon. The specimens were switched either in the urologist's office or in the lab, resulting in the son undergoing a radical prostatectomy with a normal pathology report to follow and the father being given a normal pathology report when, in reality, he was the one with the prostate cancer who needed the surgery. His diagnosis and treatment were delayed while his son had unnecessary surgery that left him impotent. The pathologists reading the specimens were sued along with the urology practice.

The lab examined the written procedures pertaining to specimen receipt and found that these procedures were followed to the letter. They discovered that the two specimens were handled by two different technicians, which meant that for a mix-up to occur both techs would have had to make simultaneous errors, which is virtually impossible to do. The lab was also able to present evidence of past deficiencies by the urology group including mixed up specimens, empty containers, male specimens labeled female and vice-versa. Furthermore, it was argued that this was the only group of surgeons that refused to use the biopsy containers provided by the lab. In the end, negligence was undisputed, and the allocation of liability was disputed between the urology group and the pathology group. However, because of the scrupulous and standardized procedures in place at the lab, SVMIC paid the majority of the loss on behalf of the urology group rather than the pathologists.

Case #2: A 60-year-old with a history of hematuria and proteinuria, underwent a kidney biopsy complicated by hemorrhage and hypertension. One week later it was discovered that the biopsy specimen was missing. The biopsy had to be repeated. In retrospective review; it was discovered the specimen was reviewed in the frozen section lab, determined to be adequate and given to the transporters. The specimen was recorded in two logs and the specimen and paperwork placed in a biohazard bag for transport. The transporter took the specimen to the lab and left it on the counter. The specimen was never accessioned. A thorough search took place in the frozen section suite and in the waste, as well as the transporter's car and in the lab waste. Further investigation of chain of custody, log-in and transport processes also took place. The employees handling the specimens were long term and well experienced with a track record of no specimen having been lost at that lab in years. Once again, negligence was undisputed. The claim was settled for an amount that would cover costs to pay for the repeat biopsy and other medical costs.

Following this incident, changes were made by the lab for future transfers. Rather than use a courier to transport the specimens from the frozen section suite to the lab, it was decided that Fed Ex would be used and the transport bag would be stapled shut. Furthermore, the specimen transport log was to be faxed to the lab to verify the delivery of specimens as they arrived. Any specimen delivered to the lab was to be entered into the log book. A weekly check was initiated for any specimens not signed into the log.

Case #3: A 45-year-old female underwent a gastric biopsy as an inpatient. The biopsy was sent to the pathology services lab and read as atypical but benign. Slides from the biopsy material later read by another lab showed a diagnosis of malignant lymphoma. Subsequent testing showed no cancer but rather contamination of the original biopsy material. Since male colon tissue was mixed in with this female's gastric biopsy on every paraffin block, the slides were contaminated either by the GI clinic or in the pathology lab. The GI clinic was suspected of affixing the labels to containers prior to the procedure, which could have led to the wrong container being selected for the specimen. However, this was never confirmed. The case was settled, in part due to the significant risks of the finger pointing between the defendants.

Analytical phase mix-ups:

Case #1: An 82-year-old man with a history of stomach cancer had several biopsies taken by his surgeon, including one from the umbilicus and one from the chest wall. The chest specimen was reported as adenocarcinoma when the cancer was actually in the umbilicus. The patient underwent an unnecessary wide excision of the chest wall. The pathologist accepted the blame by acknowledging that he mixed up the two specimens. It was suspected that he had more than one case file open at a time so that the accidental entry of data into the wrong file was possible. The patient sought recovery for medical bills, pain and suffering.

Case #2: A 36-year-old male was referred by his primary care physician to a head and neck surgeon with complaints of a lump in his throat. He underwent a fine needle aspirate of the submandibular lump. The pathology report was negative for malignancy. A month later, the patient had a lymphadenectomy done. The specimen pathology was reported as "no immunophenotypic evidence of non-Hodgkin lymphoma". The patient continued with swelling and knots in his throat. He was referred by his head and neck surgeon for consult where he underwent another biopsy. This biopsy returned positive for Classic Hodgkin's Lymphoma. The initial slides were requested for review and were also read as positive for Classic Hodgkin's Lymphoma. The patient underwent a lengthy treatment process of chemotherapy and radiation therapy.

A lawsuit was filed alleging delay in diagnosis, which, in turn, required a more aggressive treatment. The defendant admitted liability for missing a diagnosis that was obvious. He believed he likely picked up the wrong tray of slides (it was his practice to have the slides and paperwork of two patients on one tray) and failed to validate the name and the identification number on the paperwork with the name and number on the slides.

LESSONS LEARNED:

Better defenses can be asserted by doing the following:

1. In the operating room, labeling of bottles and request forms should be done at the time of the procedure. Mix-ups have occurred when labels have been affixed to

containers prior to the biopsy. This practice should be prohibited as sometimes there is a change in the sequence of biopsies or another biopsy is added.
2. Check specimen bottles and request forms for completeness. The submitting physician/surgeon should be the one completing the request forms so that adequate information is provided.
3. Workplaces in the lab and in the pathologist's office should be tidy.
4. Standardization is key.
5. Have well documented and consistently used processes for accessioning.
6. If possible, have two individuals involved during accessioning of specimens in the lab; including unpacking, sorting and numbering of bottles and request forms.
7. Track any deficiencies by type and physician office.
8. Never allow files on two patients to be open at the same time as it increases the possibility that data from one patient may be interpreted or included for another patient.
9. Never have the specimen slides of two different patients on one tray.
10. Add color coding to the slides and paperwork.
11. Minimize distractions when reading studies.
12. Perception and interpretation can improve by availing yourself of all readily accessible clinical information.
13. Proofread your voice dictation or transcribed reports for errors (example: mucinous cystadenoma vs. mucinous cystadenocarcinoma), deleted words, and confusing or conflicting statements before signing. Inaccuracies can look sloppy to a jury and communicate indifference and a lack of care or concern for the patient.
14. Document all non-routine communications including the time and method of communication and, specifically, the name of the person to whom the communication was delivered. Such documentation is best placed in the pathology report, but may be entered in a department log. Examples of these situations follow;
    1. Communication with the referring physician regarding a discrepancy between the preliminary and final diagnosis.
    2. Communication with the referring physician regarding urgent or unexpected findings including the critical values defined by lab policy.
    3. Communication with the referring physician in situations where a small sample size or poor quality of tissue fixation may limit interpretation of a specimen.
    4. Communication with a patient about the risks/alternatives of the procedure (i.e. when performing a bone marrow biopsy or fine needle aspiration). The pathologist performing the procedure should obtain the patient's consent. This conversation should be documented in the procedure note along with indications for the procedure and potential complications. The hospital consent form is typically a generic form, which is not sufficient to describe the conversation that took place with the patient.
15. Document instances where a comparison is made with prior pathology case material and/or reports.
16. Use a corrected, amended or addendum report to make any changes to a verified pathology report and to document errors.

17. Implement a system to communicate the results of amended reports. Use a corrected report and if significant, speak with the referring physician and document having done so.
18. Implement a system to communicate abnormal findings when the patient has been discharged prior to receiving results. If significant, personally communicate findings to the referring physician. Document all efforts to communicate with the treating physician, along with the information that was relayed in the “Comments” section of the report.

Be aware that the person signing the report may bear all or partial responsibility for the content of the report, even when signing on behalf of a colleague. The signer of the report should look at the slide(s) to seek agreement with the findings. Resolve any disagreements before reporting the results.

Enhancements Added to SVMIC Cybersecurity Insurance

Cybersecurity Insurance Coverage with a limit of $50,000 was first added to SVMIC's physician and practice entity policies as of January 1, 2015. This supplemental insurance was added at no additional charge and covers privacy breach response costs; cyber extortion expenses; security and privacy liability; network asset protection; cyber terrorism expenses; multimedia liability; and privacy regulatory defense expenses.

During the first two years of this coverage, SVMIC received 67 cyber-related claim reports—a majority of which were related to privacy or security breaches. These resulted in legal expenses; computer forensic and investigation fees; and patient notification expenses. There were also ten data loss or digital assets loss claims and five cyber extortion claims.

As of January 1, 2017, the Cybersecurity Insurance has been enhanced to include: 1) loss of revenue from an adverse media report and/or notification to patients of a security or privacy breach ("Brandguard"); 2) Payment Card Industry Data Security Standard (PCI DSS) Assessment coverage; and 3) the privacy breach response coverage now provides for proactive response expenses to a breach before an adverse media report in order to mitigate the damage to the practice's reputation.

For a more complete description of these coverages, visit SVMIC's website or call SVMIC at (615) 377-1999. In addition, please call for more information on higher limits that are available for an additional premium.
