



Hot Button Issue

CURES Mandatory Use Has Begun

Protecting Your Practice

A Guide to Medical Malpractice Coverage

Risk Management

Is It Too Risky to Hire Nurse Practitioners and Physician Assistants?

PHYSICIAN

Managing a Safe and Successful Practice

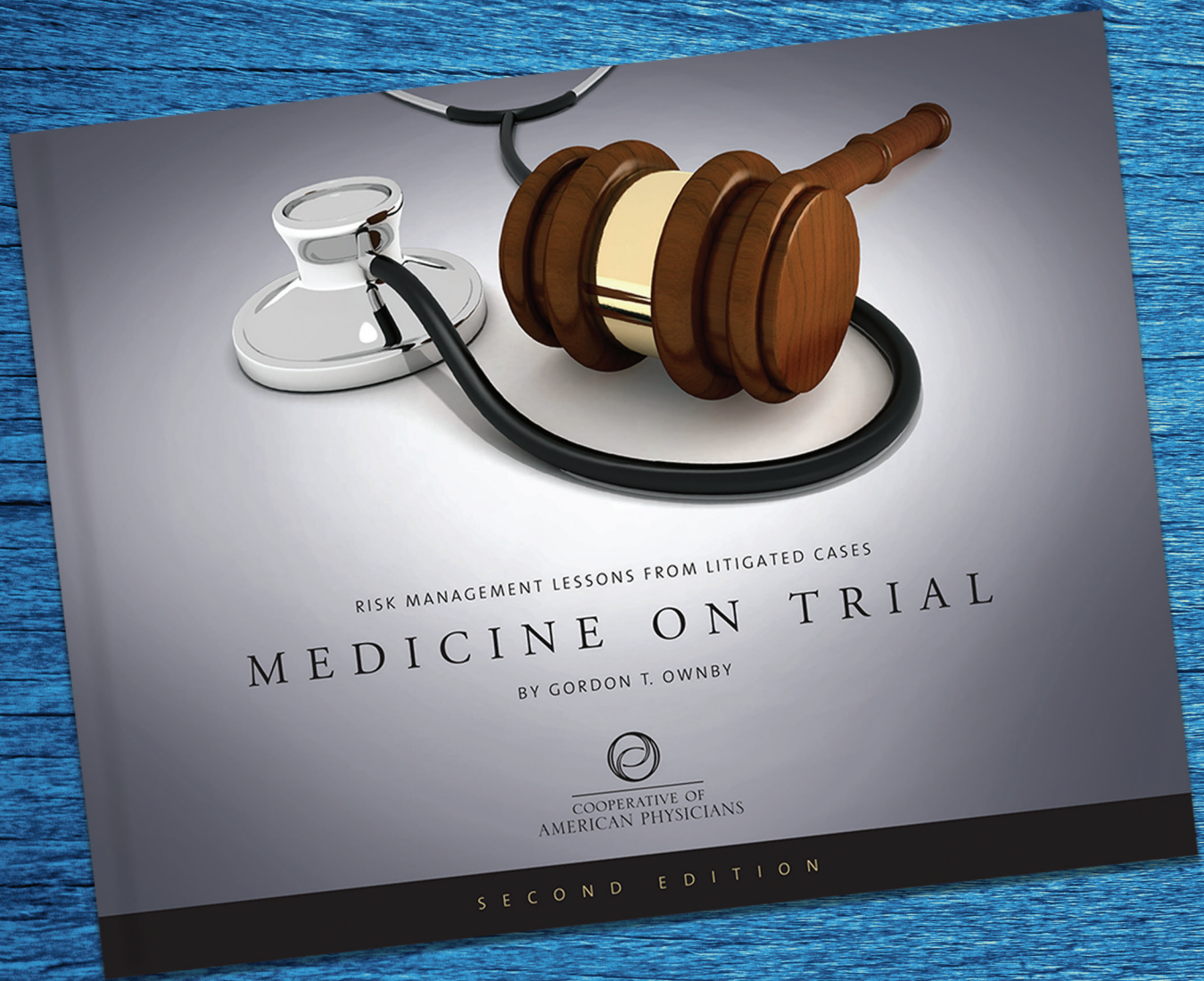
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COOPERATIVE OF
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A MESSAGE FROM THE CEO

Supporting and Protecting Physicians and Medical Practices



As an organization dedicated to the success of independent physicians, we are aware of the inherent challenges of operating a practice in today's complex healthcare environment. That is precisely why the Cooperative of American Physicians (CAP) has launched our newest practice management publication, *Physician Today*.

Penned by CAP and associated industry experts, each article offers valuable takeaways to help you stay in the know, and out of the courtroom. For example, inside you'll find:

- The latest on CURES 2.0.
- Our story on Advanced Practice Professionals, which offers best practices to help mitigate increasing liability risks among this segment of providers.
- A case study warning of the risks of a noncompliant patient.
- Tips and recommendations to help you with the day-to-day challenges of practice management, to alleviate stress, and achieve financial success.

For more than 40 years, CAP has protected our physician members with superior medical malpractice coverage supported by education and advocacy. We are proud to share our wealth of knowledge to help independent physicians throughout the state of California deliver the best care possible, while realizing personal and professional success.

If you would like additional copies of *Physician Today* for your office or colleagues, or have recommendations on topics you'd like to see covered in future issues, contact us at communications@CAPphysicians.com. We'd love to hear from you!

Sincerely,

Sarah E. Pacini, JD
Chief Executive Officer

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Physician Today is a publication of the Cooperative of American Physicians, Inc. The information provided in the articles and content in this publication is current as of the publication date.

The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.



HOT BUTTON ISSUE

Kimbelrly Danebrock, JD, RN, CPPS
Director of Risk Management, CAPAssurance



CURES 2.0: Mandatory Use Has Begun

The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for statewide use by the Department of Justice (DOJ) on April 2, 2018. Effective October 2, 2018, it is now mandatory for all healthcare practitioners who prescribe to consult and review the CURES 2.0 system prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance. A healthcare practitioner who fails to consult the CURES database must be referred to their state professional licensing board for administrative sanctions, as deemed appropriate by that board.

The law requires a healthcare practitioner to check when prescribing a Schedule II-IV medication for the first time, and at least once every four months thereafter if the

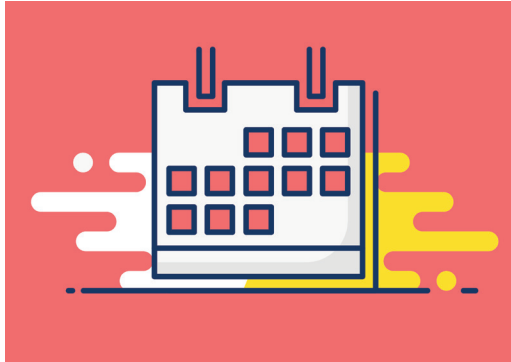
medication remains part of the patient's treatment plan. Prescribers will also be required to obtain and use tamper-resistant prescription forms ordered only from state-approved security printers.

The Medical Board of California provides further information on everything you need to know to meet compliance, including exemptions and what to do in the case of technical difficulty.

Visit www.mbc.ca.gov/CURES
for detailed information regarding
CURES 2.0.

continued

CURES 2.0 Exemptions



As of this publication date, a healthcare practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance in any of the following circumstances:

- If the controlled substance is administered while the patient is admitted to, or during an emergency transfer between a facility as specified by law.
- If the controlled substance is prescribed, ordered, or administered in the emergency department of a general acute care hospital and the quantity does not exceed a non-refillable seven-day supply.
- If the controlled substance is prescribed, ordered, or administered to a patient as part of a patient's treatment for a surgical procedure in a facility as specified by law, and the quantity does not exceed a non-refillable five-day supply.

- If the controlled substance is prescribed, ordered, or administered to a patient receiving hospice care as specified by law.

- If (1) it is not reasonably possible for a physician to access the information in the CURES database in a timely manner, (2) another physician, who can access the CURES database, is not reasonably available, and (3) the quantity of the controlled substance does not exceed a non-refillable five-day supply of the controlled substance.

- If there are technical difficulties accessing CURES, such as CURES is temporarily unavailable for system maintenance, or you experience temporary technological or electrical failure and CURES cannot be accessed (e.g. power outage or inclement weather).

- If consultation of CURES would result in a patient's inability to obtain a prescription in a timely manner and it will impact the patient's medical condition and the quantity does not exceed a non-refillable five-day supply.

For more information, please visit the Medical Board of California:
www.mbc.ca.gov/Licensees/Prescribing/CURES

For help with CURES, contact the Medical Board of California Help Desk:
webmaster@mbc.ca.gov
800-633-2322

ON THE HILL

Miranda Franco, MA,
Senior Policy Advisor, Holland & Knight



Congress passes H.R.6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

For more information, please see the section-by-section summary of H.R.6: https://energycommerce.house.gov/wp-content/uploads/2018/09/HR6_09.26.18-Final-Opioid-Sec-by-Sec-BIPART-BICAM.pdf

On October 3, 2018, the United States Senate passed a bipartisan opioids package with a sweeping vote of 98 to 1, after the U.S. House of Representatives passed the final version of the bill with a vote of 393 to 8. The President signed the bill on October 24. The 660-page bill encompasses over 75 pieces of legislation from both the House and Senate and includes several provisions that would expand access to addiction treatment, including a proposal to allow Medicaid reimbursement for additional inpatient addiction treatment facilities by partially lifting the decades-old Institutions for Mental Diseases (IMD) exclusion rule. However, the bill did not address one of the most significant issues that arose during the development of the legislation: Part 2 privacy for substance abuse records.

Other policies focus broadly on prevention, research and data collection, payment and reimbursement, support for local communities, target patient populations, law enforcement, and prescribing processes and practices. While there appear to be many policy changes, some argue that the efforts are low-hanging fruit and that the bill does not include enough federal investment. With that said, there are some meaningful changes to policies in Medicare and Medicaid in H.R.6, including but not limited to:

Medicare

- Require Part D plans to establish drug management programs for at-risk beneficiaries
- Require e-prescribing for coverage of prescription drugs that are controlled substances under the Part D program
- Create a pass-through payment extension to encourage the development of clinically superior non-opioid drugs
- Add a review of current opioid prescriptions and, as appropriate, a screening for opioid use disorder (OUD) as part of the “Welcome to Medicare” initial examination
- Incentivize post-surgical injections as a pain treatment alternative to opioids by reversing a reimbursement cut for these treatments in the Ambulatory Surgery Center setting
- Provide access to Medication-Assisted Treatment (MAT)
- Evaluate the utilization of telehealth services in treating substance abuse disorder (SUD)

Medicaid

- Require state Medicaid programs to have safety edits in place for opioid refills, monitor concurrent drug prescribing, and monitor antipsychotic prescribing for children
- Continue Medicaid coverage for youth in foster care until the age of 26 if they move out of state
- Provide additional incentives for Medicaid health homes for patients with SUD

PROTECTING YOUR PRACTICE

A Guide to Medical Malpractice Coverage

*Daniel Cavanaugh
Vice President*

Membership Development, CAP

Medical professional liability protection is one of the most important lines of coverage that physicians will purchase.

Selecting the appropriate coverage and the right company can be confusing and time consuming, given all the available options.

Physicians who have chosen to remain independent can obtain medical professional liability (MPL) coverage for the full scope of their medical practice, directly from a professional liability company or through an intermediary, such as an insurance agent or broker.

We offer some basic guidance for physicians and practice managers to take into account when reviewing MPL coverage options for their groups or for their own independent practices:

Selecting appropriate coverage for your needs:

- Verify that the policy covers you if you add or delete procedures within your practice, take a leave of absence, or change from full-time to part-time status.
- Make sure all locum tenens, physician assistants, nurse practitioners, and other mid-level providers under your supervision are covered for the full scope of services provided on behalf of the practice.
- Consider whether your liability limits are sufficient for your practice, based on the legal environment in your state, as well

as any minimum requirements imposed by state regulations, local hospitals and health plans. While \$1 million/\$3 million limits are the most commonplace, there are still some states with requirements as low as \$100,000 per claim/\$300,000 aggregate, and some with no limit requirements at all. Despite the fact that claim frequency is down nationally since 2006, claim severity continues to rise.

- When possible, it is important to obtain coverage that will pay for defense expenses in addition to the limits of liability. One of the key drivers of increased claim severity is the escalating cost of defending physicians in complex cases. If the limits are depleted by accumulating defense costs, physicians may feel pressure to accept a settlement in order to avoid having to pay damages beyond the limits of their coverage.

- Most companies provide individual limits per physician. However, for certain kinds of practices (e.g., Emergency Medicine and Urgent Care), a single limit can be shared by all the physicians and the entity, with rates based on the volume and acuity level of patient encounters, rather than the total physician count.

- Inquire as to the availability of entity coverage. Physicians are directly liable for

the care they provide, but their medical group also has “vicarious liability” for the acts of all healthcare providers working in the practice. As the shortage of primary care physicians continues unabated and an increased number of patients have access to medical services under the ACA, the volume of care that is being provided by nurse practitioners and physician assistants has continued to grow. This creates additional liability for the medical groups and other healthcare entities that employ mid-level providers.

Company selection and important coverage provisions:

- **Financial strength:** It is essential to secure coverage with a company that will have the financial resources to provide an adequate defense, if needed. Look for a company with an A.M. Best rating of A (Excellent) or higher, which is indicative of a company’s ability to pay claims. It is worth noting that many hospitals and health plans outline minimum best rating requirements within their medical staff guidelines and provider agreements.
- **Consent to settle:** Make sure the policy prohibits the company from settling any claims without the physician’s consent, and that there are no financial penalties if the physician withholds consent for an unfavorable settlement (i.e. “Hammer Clause”). In tough cases, physicians need a company that will stick with them and fight to protect their reputation and their practice.
- **Defense outside limits:** Defense costs should not deplete the limits of liability, which must be preserved for settlements and judgments.

■ **Retirement tail:** The coverage should stipulate that free tail is provided at retirement or upon death or permanent disability.

■ **Supplemental lines of coverage:** Some professional liability companies (including those available through the Cooperative of American Physicians, Inc.) are now offering supplemental lines of coverage for other medical practice exposures:

- Cyber Liability for ransomware attacks and electronic breaches of patient data, Protected Health Information (PHI) and Personally Identifiable Information (PII).
- Regulatory issues such as HIPAA, EMTALA, and Medicare/Medicaid Billing Fraud and Abuse.
- Wrongful termination, sexual harassment, hostile work environment, and other employment-related lawsuits.
- Administrative Defense Coverage for disciplinary proceedings related to professional conduct/competency issues, including actions by a professional review body (hospital or managed care organization), or state licensing board.
- General liability for office premises exposures (e.g., slip and fall).

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PATIENT DOCUMENTATION

Documentation is Key When it Comes to Problem Patients

*Noncompliant patients:
Perhaps the only physicians who do not have them work in the Coroner's Office.*



*Gordon Ownby
General Counsel, CAP*



When physicians deal with patients who will not follow their advice for further tests and follow-up visits, apprehension over liability is probably second only to concern over the patient's health. While there is only so much a physician can do to safeguard the health of these patients, protecting against a lawsuit is a matter of diligence and documentation.

Dr. "IM", an internist, treated a middle-aged gentleman with diabetes and gall bladder disease over an eight-year period. At the end of the first year, the patient developed pulmonary coccidioidomycosis, requiring hospitalization, bronchoscopy, and transbronchial lung biopsy. A specialist treating the patient during the hospitalization found no malignancy and treated the patient with IV Erythromycin and Zinacef. The patient remained on antibiotic therapy for the next year, but also developed a fungal pneumonia.

During the next two years, Dr. IM managed the patient's diabetes, seeing the patient five to six times per year. However, the frequency of visits dropped and the patient made only one visit the next year, despite the doctor's use of appointment-reminder cards, notations of which were made in the records.

The patient returned a year later when he suffered from flu-like symptoms, including coughing, fatigue, and a slight temperature.

On the next visit, the patient showed no improvement. Dr. IM ordered a chest X-ray. The radiologist reported moderate right and left pleural effusion and recommended a chest CT scan. When Dr. IM reported the abnormal CXR results, the patient refused a referral to a pulmonologist. The patient did say that he would undergo the CT scan, and Dr. IM also prescribed Lasix.

The patient returned in a month but had not made an appointment with the radiologist for the scan. Though the patient reported that he was breathing better, Dr. IM told him that he was still concerned about the pleural effusion and that he needed to have the chest CT performed.

On the next visit a month later, the patient had still not gone for the scan. Dr. IM noted decreased breath sounds at the lung bases and noted significant fluid retention. Dr. IM told the patient that he must have the scan done as soon as possible.

The patient finally visited the radiologist three weeks later. The CT scan revealed a large bilateral pleural effusion and borderline enlargement of the left adrenal gland. The right middle and right lower lobes of the lung were nearly collapsed. According to the radiologist, these presentations were new from the X-ray done three months earlier.

Dr. IM referred the patient to a pulmonary specialist for follow-up. Though Dr. IM had no further contact with the patient, his chart did contain another CT scan performed a month after the first.

This scan showed mild enlargement of the left adrenal gland and persistent bilateral pleural effusion.

Some three months after the patient's last visit, Dr. IM received a telephone call from the patient's family informing him of the patient's death. That same month, the family requested the patient's medical records. Then, just a day short of the one-year period for filing a suit for personal injury, Dr. IM received a letter from the patient's brother mentioning an intention to sue and citing Code of Civil Procedure Section 364, the so-called 90-day notice statute.

Despite that letter, the preparation of which showed some legal knowledge, no one ever sued Dr. IM. Most likely, any attorney reviewing the records noted the patient's chronic noncompliance. More importantly, the records showed Dr. IM's consistent attempts to keep the patient on schedule and repeated warnings on the importance of obtaining the CT scan.

Though the first goal of any doctor's approach to a noncompliant patient is to motivate the individual to get the necessary care, the documentation of those efforts has the added benefit of helping to defend against a lawsuit that may still arise.

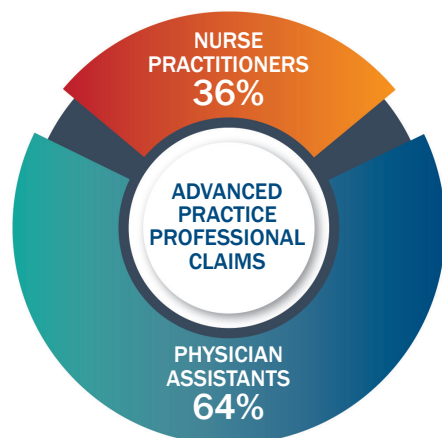
RISK MANAGEMENT

Is it too Risky to Hire Nurse Practitioners and Physician Assistants?

Ann Whitehead, JD, RN
Vice President, Risk Management, CAP

Employment trends indicate an increasing number of Advanced Practice Professionals (APPs), specifically nurse practitioners and physician assistants in healthcare settings.

CAP risk management staff evaluated 42 closed claims involving APPs to identify trends and to develop strategies for our members and their APPs that will improve patient care and reduce medical liability. This is what we found:



Of the 42 CAP claims reviewed, physician assistants were sued nearly double the frequency as nurse practitioners. Our findings mirror an extensive study done by the Federation of State Medical Boards (FSMB).

Top 3 Allegation Categories

TREATMENT RELATED

29%

- Improper Management of Course of Treatment
- Failure to Refer/Seek Consultation
- Failure to Manage Pregnancy

DIAGNOSIS RELATED

26%

- Failure to Diagnose

MEDICATION RELATED

21%

- Improper Management of Medication Regime

ALLEGATIONS »

Of the 42 cases reviewed, the top five patient allegations (listed above) made up nearly half (47%) of the claims. Except for Failure to Manage Pregnancy, these patient allegations appeared most often in cases where patients were later diagnosed or treated for infections or fractures.

Managing Advanced Practice Professionals: Best Practices

Building a strong foundation in excellent care and patient safety begins with ensuring that the APP is qualified, competent, and knowledgeable of his or her role. CAP recommends the following risk management strategies to reduce medical liability:



Employment – *Take your time when hiring a nurse practitioner (NP) or physician assistant (PA).*

- Evaluate credentials: verify graduation from an accredited program and active licensure. NPs are licensed by the California Board of Registered Nursing. PAs are licensed by the Physician Assistant Board, a division of the Medical Board of California.
- Perform background checks, including criminal and professional board actions.
- Verify professional liability coverage and obtain a copy of current policy. Investigate malpractice claims history with the National Practitioner's Data Bank (NPDB).
- Contact all references, including past supervising physicians and coworkers.



Education and Training – *Play an essential role in mentoring and fostering APPs' educational development. Recognize that no two APPs are created equal—each professional has a unique skill set and level of experience.*

- Utilize skill checklists to determine deficiencies and areas of competency.
- Provide ongoing on-the-job training, especially for those new to practice. Longer training time may be needed if the APP is working in a group setting with multiple physicians. Experienced APPs will benefit from an orientation where performance expectations and practice standards are clarified.
- Support professional growth and need for continuing education. Consider topics relevant to clinical practice—communication, empathy, managing patient expectations, and improving patient satisfaction.



Comprehensive Written Protocols – *Liability can be mitigated by tighter adherence to clinical guidelines.*

- Understand state laws and regulations that define the APPs scope of practice.
- Clearly define their role in a written job description within the Standardized Procedures and Protocols (SPP) for the NP or the Delegation of Services Agreement (DSA) for the PA.

- Define their scope of practice. Protocols should outline the types of patients APPs can manage independently, the treatments they can provide, the type of drugs they can prescribe, and the type of procedures they can perform.
- Outline the types of problems, conditions, and clinical complaints that require real-time consultation with a physician, or a referral to a specialist.

These two categories of interventions can directly improve patient outcomes and prevent problems associated with ineffective communication and the lack of supervision, further reducing medical liability.



Collaborative Relationship – *Patients' lives depend on effective communication and teamwork.*

- Create a “culture of safety”: encourage open communication and value good internal relationships; invite consultation; be available and approachable—your APP will feel more comfortable asking important clinical questions and seeking your guidance and involvement in patient care.
- Prioritize provider well-being and participation in quality improvement and workplace changes. Research solidly correlates a clinician’s job satisfaction with favorable patient outcomes and improved patient satisfaction.



Supervision – *Don't be left out of the loop! Understand your role as a supervisor.*

- Understand state laws and regulations; recognize that legal regulations are the minimum requirement.
- Conduct frequent meetings to discuss patient care, review charts, resolve conflicts, and reinforce policies and procedures.
- Maintain records of periodic performance evaluations and chart reviews in personnel files.
- Document all consultations with the APP—a simple note in the chart is sufficient.

Additional APP-related Resources:

Cooperative of American Physicians
www.capphysicians.com

The Medical Board of California
www.mbc.ca.gov

California Board of Registered Nursing
www.rn.ca.gov

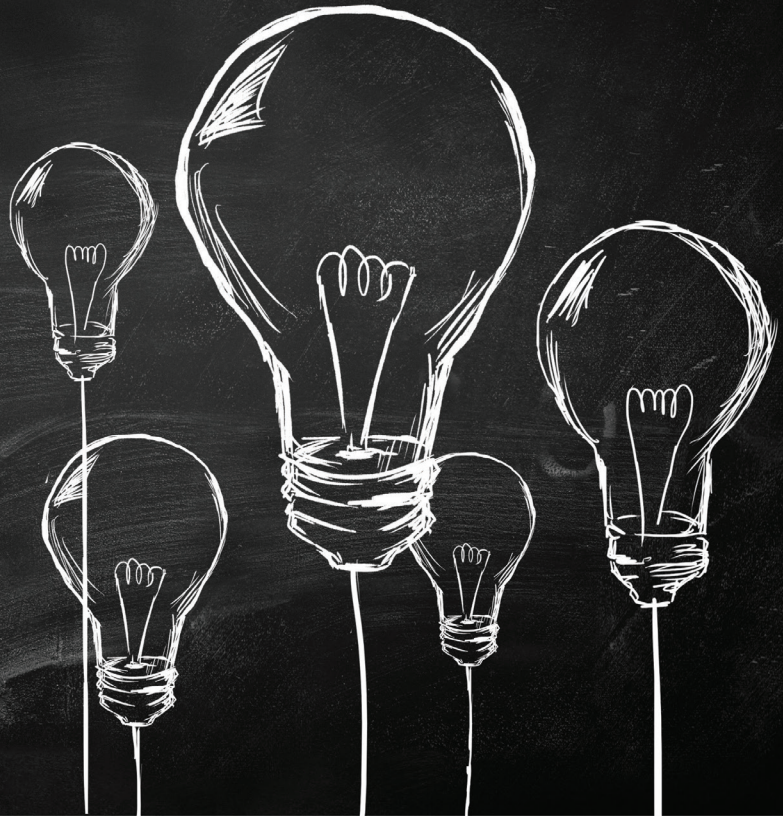
Department of Consumer Affairs' Physician Assistant Board
www.pac.ca.gov

The National Practitioner Data Bank
www.npdb.hrsa.gov



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SMART GOALS



What are SMART Goals and How Can They Work for Your Practice?

*June McKernan
Practice Manager
Patient Preferred Dermatology Medical Group, Inc.*

Whether you are the lead physician or practice manager, you should know how to set up a strategic business plan using SMART Goals. There is a lot of information online about this system. SMART Goals can be used in your practice and in your personal life.

They are especially helpful in practice development. SMART Goals can and should positively impact many areas of your work and life, helping you reach higher levels of organization and achievement.

S

Establish **SPECIFIC** Goals for Your Practice

Monthly Examples:

- Number of new patients
- Number of established patients
- Total charges
- Total payments

Annual examples:

- Adding new technology
 - Adding new provider(s)
 - Adding new service(s)
 - Opening a satellite office
-

M

Your Goal Needs to be **MEASURABLE**

Examples:

- Goal is: 2,500 patients a year (or 208 patients a month).
 - Goal is: \$4 million a year (or \$333,400 a month).
 - Compare your goals to industry benchmarks.
 - Compare your numbers to Medicare numbers.
-

A

Choose Your **ACTION** Items

Make a list of **WHAT** you need to do and **HOW** you are going to achieve it

Examples:

- Manager will place an ad for a new physician.
 - Doctor will contact the medical school to see if there are any interested new grads.
 - Manager will contact medical societies.
 - Doctor will speak to physicians at the hospital for potential leads.
-

R

Keep Your Goals **REALISTIC**

They need to be reachable, not unreasonable

Examples:

- If the industry growth is 10%, setting a goal of 40% may be unrealistic.
 - If you want to double your income, yet not work additional hours or add an additional provider, you most likely will not reach that goal, as it is not reasonable.
-

T

Build a **TIME-BASED** Factor into Your Goals

Examples:

- Add a new provider by a specific date.
- Purchase a new laser before November.
- Update the office policy in August.
- Review and update the compliance plan in September.
- Create a social media marketing plan during the third quarter of the year.
- Review the annual budget in November.

Dear Cappy

ADVICE COLUMN

Online Reputation

Dear Cappy,

A patient left me a one-star Yelp review and I don't even know why. Can I sue him?

Dr. Actually Five Stars

**Dear Dr.
Actually Five
Stars,**

Not recommended. Even the most experienced physicians will receive negative feedback occasionally. If you receive a negative review, respond only in generalities. And be certain to offer the reviewer a way to contact you offline to further discuss his or her concerns. Be careful to respond without revealing any patient health information (PHI) and accidentally violating the Health Insurance Portability and Accountability Act (HIPAA).

The following is an appropriate response:

Thanks for your review. We value all constructive criticism and welcome the chance to discuss your concerns to improve our patient care. Please contact us at [contact info] if you wish to discuss this further.

Remember: The best way to respond to negative reviews is by having your satisfied patients outnumber them. Doing this makes negative reviews exceptions to the rule.

Utilize negative reviews as a learning experience. Mistakes happen, and getting feedback from patients is a great way to learn, improve, and transform your practice.

Cappy

TIPS

To get a positive online reputation, you have to earn it. It's essential that every patient who walks through your door feels important and has your full attention.

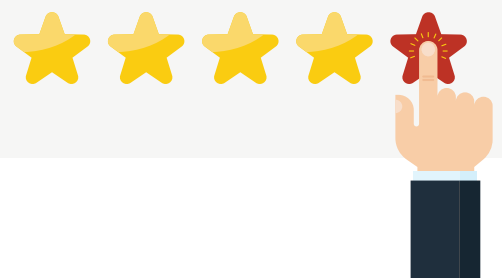
Make notes in your patient's chart with personal details about who they are—what they do for work, their children's names, etc. Know who they are and show that you care.

Try to personally call or write to thank patients who refer their friends or colleagues.

After a patient has a good experience with you, ask them to write about their experience online and tell them that their feedback would be very helpful.

Be sure your patients know that their opinion matters, and always express gratitude after they share their positive experience.

Listen to what your patients say about you.



Patient Experience

Dear Cappy,

Help me settle a debate between my office staff. My receptionist likes to snack in between calls, and I don't have a problem with it. My office manager gets very upset when she smells food and makes a big stink about it. Who's wrong in this situation?

Dr. Stuck in the Middle

Dear Dr. Stuck in the Middle,

You are. By not appreciating the importance of the patient experience, you've put your office manager in a very awkward place. The everyday details of how a patient is greeted, the condition of the waiting room, and the professionalism of staff can make a big difference in patient satisfaction and even medical outcomes. Patients who are treated with courtesy and respect are less likely to form negative impressions and more likely to follow treatment plans and recommend the practice to others. And it can't be overemphasized that patients who are happy with the way they are treated by physician and staff are less likely to file a claim for a real or perceived grievance.

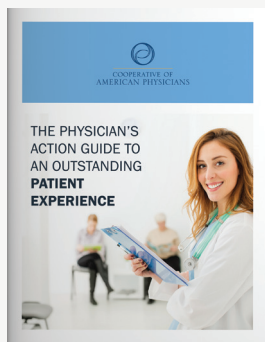
As a general rule, staff members should eat only in non-patient areas. It's not uncommon to hear patients complain that food odors, such as popcorn, broccoli, and fish, are nauseating. Tell your receptionist to limit her snacking to when she is away from her desk.

Cappy

TIPS

8 of the Easiest Things You Can Do to Dramatically Improve Patient Safety and Satisfaction:

- 1 To respect modesty, make sure staff close exam room doors and a chaperone is present when the doctor sees the patient.
- 2 All staff should eat in non-patient areas—strong odors, such as fish or broccoli, can make patients feel nauseous or just be offensive.
- 3 Prescription pads, medication/product samples, and syringes should be secured, out of sight, and placed away from patients—especially children.
- 4 Make sure all electronic data have offsite, remote back-up.
- 5 Set an automatic password reset for your EHR system every 60 to 90 days to ensure privacy and security.
- 6 Document all missed appointments and attempts to reach “no show” patients.
- 7 Make sure all refill requests are approved by the physician.
- 8 Reward and recognize staff for submitting ideas to increase patient safety and improve the overall quality of care in the practice.



CAP has recently published its comprehensive *The Physician's Action Guide to an Outstanding Patient Experience* to help you optimize the patient experience. We are pleased to offer you this guide free for the asking to help ensure that your patients feel cared for, are fully prepared to comply with your course of treatment, and feel confident in your expertise and your staff's capabilities. Get your free copy by calling 800-356-5672 or visiting www.CAPphysicians.com/PEPT.

THE OFFICE

How Much Can You Charge a Patient for Medical Records?

*Kimberly Danebrock, JD, RN, CPPS
Director of Risk Management, CAPAssurance*

We all know patients in California have a right to review their medical records and/or obtain a copy. It is also no surprise that healthcare providers are typically allowed to charge a fee for this service. However, with all the different rules and exceptions, copying fees can be confusing.

Since most, if not all, medical offices are “covered entities” under the federal privacy laws, and therefore subject to the Health Insurance Portability and Accountability Act (HIPAA), it is important for physicians and their staff to be aware of the differences in state and federal law, and know which to follow.

Copy Fees

When the patient requests his or her own medical records, California law (Health & Safety Code §123110) allows healthcare providers to charge a patient or their legal representative a maximum of \$0.25 per page, or \$0.50 per page for records copied from microfilm. A reasonable clerical fee is also allowed, as long as the amount charged does not exceed the actual costs of preparing the medical records.

However, confusion occurs because the HIPAA Privacy Rule, which is federal law and applies to almost every medical office, has different regulations regarding what a healthcare provider can charge when a patient requests his or her medical

records. According to the Privacy Rule, below are the guidelines that healthcare providers must follow.

Reasonable Clerical Fee

Physicians can charge a “reasonable, cost-based fee,” which means they can only charge for:

- Labor for copying the medical records, whether paper or electronic
- Supplies for copying the medical record on paper or electronic portable media, if the patient requests the records be provided in electronic format (if the medical office maintains patient information in an electronic health record, federal law requires it to be provided to the patient in electronic format if the patient makes that request)
- Postage, if applicable
- Preparing a summary of the medical record, if the patient agrees to that process in lieu of obtaining the actual medical record

Clerical Fee Not Allowed

Some medical offices charge the patient a fee for the staff to locate the medical records, especially if the medical records are off-site. Although this is allowed under

California law, it is not allowed under federal law (the one you should likely be following). Therefore, this fee is not allowed.

When the patient requests electronic health records or paper charts maintained in electronic format, the Privacy Rule does not allow the physician to charge more than the actual costs of labor. In other words, per page fees are not permitted for paper or electronic copies of medical records maintained electronically. Nor does the Privacy Rule allow for charging a retrieval fee for the medical records if they must be located.

Flat Fee for Electronic Copies of Medical Records Maintained Electronically

An office may charge a flat fee for patients who are requesting a copy of their medical records. However, this fee cannot exceed \$6.50, including postage, labor, and supplies.

Copy Charges Not Allowed

It is just as important for physicians and staff to know when they cannot charge a patient for a copy of their medical records. Patients, former patients, or their representatives are entitled to one free copy of the relevant portion of the patient's record necessary to support an appeal regarding eligibility for a public benefit program, such as Medi-Cal or Social Security disability benefits. Please refer to Health & Safety Code §123110 for further information related to providing medical records to patients during the appeal of a public benefit program denial.

Keep in mind that to protect patient confidentiality, medical records should only be released with a written authorization from the patient (if living), or their legal representative (if the patient is deceased or incompetent).

Knowing when to follow the correct law is not always easy. But in the case where patients request their medical records, almost every medical practice will need to follow federal law under the Privacy Rule. The HIPAA Privacy Rule applies only when the patient is requesting the medical records. It does not apply when the request comes from a subpoena, a health or life insurance plan, an attorney request, or any other situation.



MED MAL RISKS

Should You Apologize After an Adverse Outcome?

Diana Douglas
Vice President, Risk Management, CAP

Empathy vs. Apology

Expressions of empathy and acknowledgment of bad or unfortunate occurrences reflect the human value of compassion and are globally recognized. Healthcare is no exception. Acknowledging the patient's emotions is encouraged. This also lets the patient see the physician's compassionate side.

It is important to understand the difference between empathy and apology.

Under California law, benevolent gestures of empathy and compassion cannot be used against a physician in a professional liability lawsuit. However, statements that reflect fault are admissible.

The following statements reflect an empathetic interaction with the patient:

"I'm sorry you are experiencing this."

"I'm sorry this happened."

"I'm sorry you are going through this."

"I'm sorry this complication occurred."

In contrast, the following statements reflect admittance of fault:

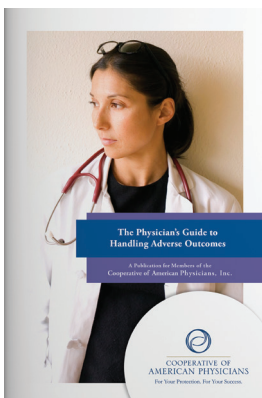
"I'm sorry; this was my fault."

"This was my mistake."

If a thorough investigation suggests that a true medical error occurred, there are multiple paths that may be taken. However, in the immediate aftermath of an adverse outcome, empathy is the best communication tool. The physician should use it wisely to reflect understanding of the patient's feelings at the time.

Thus, an apology is only offered after an investigation proves a true medical mistake has occurred. The disclosure to the patient and the apology are done in a coordinated manner and as the conditions dictate.

Remember, patients expect the situation to be taken seriously. Although physicians may have seen similar situations occur before, this experience is unfamiliar and serious to the patient. Perception management is vital at this time, and it is important that the patient does not perceive his or her physician as being insensitive to the situation. This includes using comedy to "lighten the mood" in an attempt to diffuse tension. The patient may not remember the full discussion, but will certainly remember a flippant or disrespectful comment that may obstruct further open communication.



To learn more about the steps to take following an adverse outcome, including understanding the difference between empathy and an apology, request your free copy of CAP's *The Physician's Guide to Handling Adverse Outcomes*. Effective communication can not only preserve the physician-patient relationship, but also help prevent a medical liability lawsuit. Get your free copy by calling 800-356-5672 or visiting www.CAPphysicians.com/AOPT.



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RESOURCES AT YOUR FINGERTIPS ON THE CAP WEBSITE

To support our mission to help physicians run a safer, more successful medical practice, CAP provides physicians and medical staff with a number of **free resources** and **special event announcements** on our corporate website. These include:

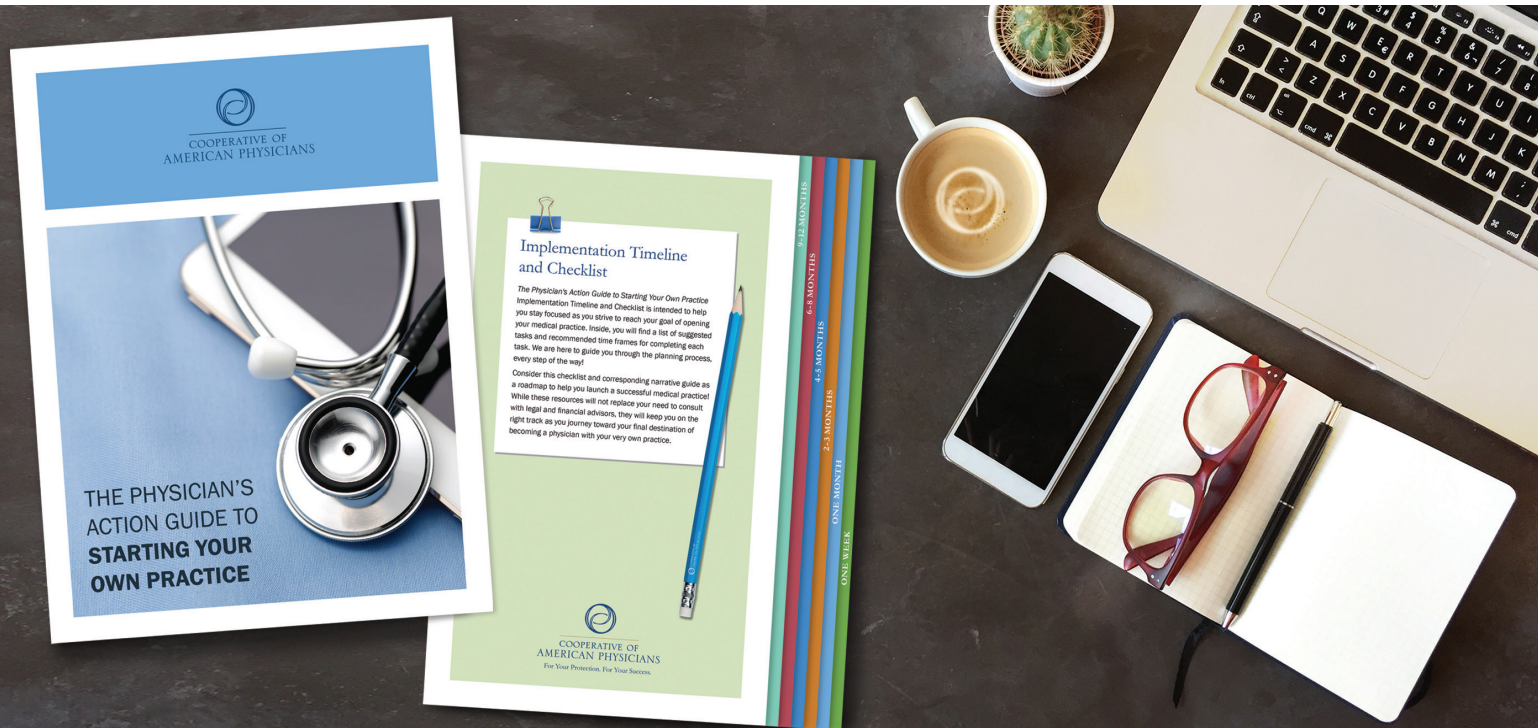
- Practice management action guides
- Risk management self-assessment kit
- HIPAA compliance resources
- Live webinar invitations
- Recorded webinars
- Links to agencies and associates to help you better run your practice
- Much more!

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