THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Case of the Month

Office Protocols Can Fail — So Training Must Be Constant

by Gordon Ownby

An omission in medical treatment is nearly impossible to defend when there is a written protocol specifically addressing the failed act. That is why an open dialogue between physician and staff on office policies and procedures is necessary to avoid patient injuries.

A six-year-old patient visited an urgent care center with his mother for right thigh pain over three days, reporting that the site was sore to the touch and hurt when he walked. The mother reported that there had been no recent trauma. Dr. UC, an urgent care physician, evaluated the patient, who was in general good health with a low-grade fever of 99.3. Dr. UC noted pain in the muscle but not the femur. Dr. UC's working diagnosis was an infection or inflammatory process and she prescribed Augmentin and Tylenol. She gave the mother ER precautions and set up a follow-up visit for two days later.

Instead of returning, the patient's mother mentioned the urgent care visit to the patient's pediatrician, Dr. PD, during a pediatric visit by the patient's sibling. The mother's comments regarding the patient's urgent care visit were noted in the patient's chart at the pediatric practice. The next day, the mother called Dr. PD's practice to request an X-ray for her son. A note in Dr. PD's chart reflected "the mother discussed with [Dr. PD] at the sibling's visit yesterday and she was okay with it." Dr. PD's staff wrote a prescription for an X-ray of the right thigh.

That same day, after Dr. UC's staff called to follow up on the earlier visit, the mother brought her son in to see Dr. UC. On examination, the young gentleman's fever had improved but he still had pain when the Tylenol wore off. An X-ray was taken and Dr. UC noted no acute changes. Dr. UC advised the mother to have her son continue with the Tylenol, follow up in two-to-three days, and visit the ER if conditions worsened.

Dr. UC's staff attempted to follow up with the family three days later, but the voicemail left by staff was not returned.

Eleven months later, the mother called Dr. UC's office requesting a copy of the X-ray taken at the urgent care center and informed Dr. UC that her son had been diagnosed with Ewing's Sarcoma a month earlier.

After that call, Dr. UC discovered that the X-ray taken at the urgent care practice was never sent out for a formal interpretation, even though the office policy was to send out all X-rays taken in-house for a board-certified radiologist's interpretation.

At the mother's request, Dr. UC then sent out the X-ray

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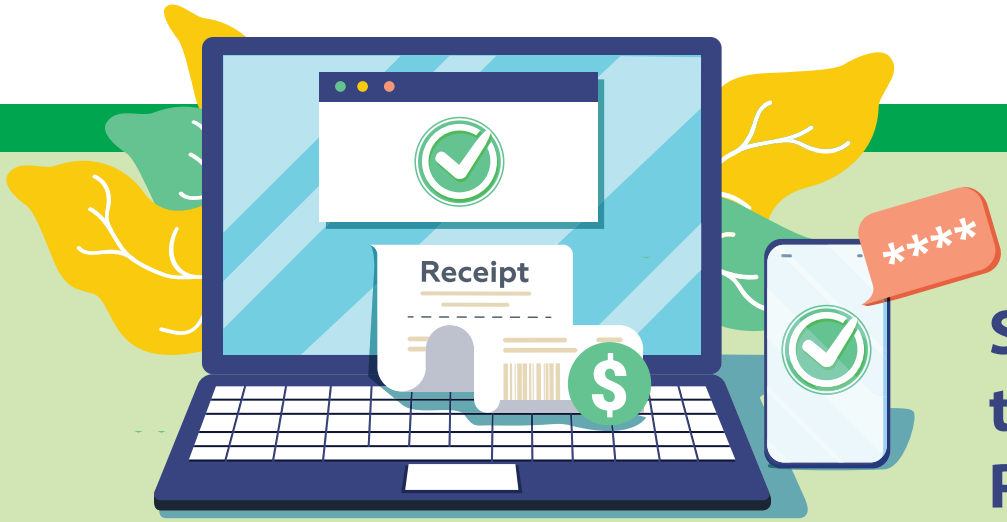
for interpretation. The receiving radiologist noted a large bone lesion involving the right femoral neck, the intertrochanteric region, and the proximal shaft. The X-ray and the radiologist's report, which included a recommended MRI to evaluate the potentially malignant lesion, were sent to the mother.

The patient sued Dr. UC alleging a 10-month delay in his cancer diagnosis, which included pulmonary and pelvic soft tissue metastases. The dispute was resolved informally.

Office protocols are not "set and forget" but need to be actively reinforced with staffers. Through the reinforcement of a continuing dialogue between physicians and staff, protocols will not only be better understood, but probably also constantly improved.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.



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February 2021

Risk Management and Patient Safety News

So, You've Been Asked to be a Medical Director?

by Dona Constantine, RN, BS

When calling CAP's Hotline, a question some physicians ask is, "Will I have additional liability if I accept a position as a medical director?" The short answer is "yes." Here are several examples:

- Dr. A became involved in Mrs. B's care as the medical director and wound care consultant of a nursing home facility. Dr. A made recommendations but did not write orders; that was left to the patient's attending physician. Dr. A made no notes in the medical record. When Mrs. B died, Dr. A's name was included in the professional liability lawsuit that alleged elder abuse.
- Dr. C accepted a financially beneficial position as medical director of a medical spa near her practice. She was responsible for supervising the registered nurse (RN) who was employed by the medical spa. After the RN performed laser hair removal, the patient was left with hyperpigmented areas. As medical director, Dr. C was named in the subsequent lawsuit filed by a patient she had never seen. The claim alleged failure to properly train and supervise the nurse who had improperly managed the treatment.

While the physicians in the above situations were eventually dismissed, each case took almost two years to conclude. That meant many months of uncertainty for the physicians involved.

Another consideration is if you are asked to serve on a utilization review committee to determine decisions of medical necessity. The Medical Board of California policy is that utilization review decisions constitute the practice of medicine and promulgated the following resolutions on May 9, 1998:

"(a) The making of a decision regarding the medical necessity or appropriateness, for an individual patient, of any treatment or other medical service, constitutes the practice of medicine.…" — CMA Health Law Library, Document # 7156, Medical Directors: Utilization Review and the Practice of Medicine, CMA Legal Counsel, January 2020

When contemplating a position as a medical director, make sure you discuss the issue with CAP Membership Services as well as CAP Risk Management and Patient Safety. Here are some questions you will be asked and some you may want to consider before saying "yes" to such a position.

Will the position be "medical director" of the entity/organization?

Coverage of medical directors (except for those serving their own medical group) is excluded under the Mutual Protection Trust Agreement. If you accept the position, consider investigating coverage for Medical Directorships through CAP Insurance Services Agency, Inc. Call 800-819-0061 for information.

Will your oversight involve any care, or healthcare providers, outside of the state of California?

CAP members enjoy coverage only within the state of California unless out-of-state coverage is specifically

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granted for specific reasons. You will likely need to secure professional liability coverage and, possibly, a medical license, in the states served.

Will your job description involve "supervision" of a physician assistant (PA), nurse practitioner (NP), registered nurse (RN), or any other California licensed healthcare professional?

PAs and NPs in California work only under defined protocols enacted by each entity and signed by the medical director. These required protocols are specific to each organization and define the scope of practice for each individual based on his or her training and expertise. Also, laws govern the supervision of other licensed personnel, e.g., a physician may not "supervise" a physical therapy technician. As a result, if a patient is injured by the actions of any of these caregivers, the medical director may be held responsible for the appropriateness of the scope of care permitted.

If you will supervise healthcare professionals or other caregivers who are not your employees, will you have hiring, firing, and disciplinary authority?

If you will not have authority over maintaining qualified, credentialed, and experienced employees, you are putting yourself at risk. As medical director, you may be held responsible for the quality and standard of care provided by the healthcare organization. Without authority over employees, it will be difficult for you to assure that quality. MPT should be notified in order to make a determination regarding coverage in this setting.

As medical director, who will be your employer?

The Medical Board of California notes, "No one who cannot legally practice medicine can offer or provide medical services. A physician contracting with or acting as an employee of a lay owned business would be aiding and abetting the unlicensed practice of medicine. To offer or provide these services, the business must be a physician-owned medical practice or a professional medical corporation with a physician being the majority stockholder." (Business and Professional Code, Sections 2052, 2264, 2286 and 2400), Medical), Board of California, Action Report, July 2006

Are the risks decreased if you entirely own the medical spa or medical organization and you serve as its medical director?

When you are the owner, you have control of employees and the development and implementation of all organizational policies and protocols. In that arrangement, you are in a better position to ensure the quality of care provided.

Has the employing company assured you that the medical director (or "consultant") has little or no liability, is an "advisor" only, or that "your name will not even appear on the medical record"?

CAP physicians report they have been told this by organizations soliciting them for medical director and consultant positions. However, unless the contract with the organization indemnifies the physician, this may not be true. Since both titles convey the impression of expertise, the "advice" will carry increased weight even if not documented as a formal order in the medical record. If a patient injury occurs as a result of practitioners following the advice, they will not hesitate to point the finger toward the medical director or consultant.

The bottom line is this:

Ask a lot of questions before you place your reputation and potential liability in someone else's hands! And, as always, when you're considering new practice opportunities, call the CAP Hotline at 800-252-0555 to discuss coverage and liability issues.

Dona Constantine is a CAP Senior Risk and Patient Safety Specialist. Questions or comments related to this article should be directed to dconstantine@CAPphysicians.com.

Growing Cyber Threat to Medical Practices

Medical practices are increasingly coming under attack by cyber criminals. This makes it all the more important that physicians take steps to improve their security efforts. Though cyber insurance is one effective way of mitigating risk, there are new tools, processes, and technologies that can proactively protect practices including, but not limited to, the conducting of a vulnerability scan.

A vulnerability scan determines whether a commonly used remote desktop protocol (RDP) port is facing the public internet and therefore potentially exploitable (similar to driving down the street to see which houses have left their front doors open).

Tokio Marine HCC (TMHCC) is the insurance company that provides cyber risk insurance coverage for all CAP members with the opportunity to purchase a higher limits policy. TMHCC partners with ePlace Solutions to offer CyberNET information as well as free HIPAA training. THMMC has now conducted a vulnerability scan across their book of business, simply with the knowledge of a policyholder's public domain. This universe included CAP policyholders, but only those policyholders for whom TMHCC had either an email or website address. Currently, these scans have only affected CAP policyholders who have purchased a higher limit Lloyd's policy renewing first quarter through third quarter of 2021.

This process is not invasive but does rely on the collection of policyholder domains and email addresses.

If an open RDP port is discovered, TMHCC, in partnership with ePlace Solutions, can offer assistance to help implement best practices to protect RDP remote access (like moving the front door to the back of the house and not viewable from the street), thereby significantly reducing the policyholder's risk of a cyber attack (like ransomware). Alternatively, an IT service provider or network administrator can address these vulnerabilities and potentially advise on what prescriptive measures can be utilized.

In the future, a representative from TMHCC or CAP Physicians Insurance Agency, Inc. (CAP Agency) may contact you if they find vulnerabilities that are increasing your risk of a cyber attack. This is a service that is available at no additional cost to all members who purchase a higher limit policy through CAP Agency.

If you would like a copy of "Frequently Asked Questions," or if you would like to apply for a higher limit policy to protect your practice in these uncertain times, please call CAP Agency at 213-619-0081.

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When a State Concern Becomes the Law of the Land

by Gabriela Villanueva

From time to time in political and policy discussions, the phrase comes up, "As goes California, so goes the nation." We can now say that with what is called "surprise medical billing."

Back in 2016, California passed AB 72 to forbid balance billing to patients for out-of-network care at in-network facilities. When AB 72 took effect on July 1, 2017, the new law imposed additional balance-billing prohibitions on "non-contracted" physicians beyond the longstanding balance-billing prohibition for emergency services. Substantial opposition to the bill followed from both national and state specialty societies and associations, including the Association of American Physicians and Surgeons, Inc. (AAPS), which had strongly encouraged then-Governor Jerry Brown to veto the bill. AAPS argued that AB 72 was flawed because of its threat to healthcare access, and in a letter pointed out that it "would essentially allow private insurance companies to fix the reimbursement rates for all physicians, including physicians who are not in-network or under contract with the insurance companies."

As the topic gained traction, in 2018 members of Congress began to introduce bills addressing the issue and framing the discussion around the need to protect patients from industry practices. U.S. Senator (and physician) Bill Cassidy (R-LA), introduced language in the Senate Health Committee and U.S. Representative (and emergency room physician) Raul Ruiz (D-CA), crafted an approach in the House. At a moment when there had been major political fallout from failing to repeal the Affordable Care Act, passing legislation to protect patients from surprise billing seemed like an easier path to a legislative win for both Republicans and Democrats. Surprise billing was one of the few areas in healthcare where something could actually pass.

But crafting bill language that would not create a greater advantage for one stakeholder over the others, in this case insurers, hospitals, and providers, would prove trickier than expected.

While insurers preferred and lobbied Congress to set reimbursement rates via a benchmark payment mechanism — something the Senate Health Committee bill by Senator Cassidy proposed — hospitals, providers, and a multitude of physician-focused societies and associations (including CAP) advocated and lobbied for an independent dispute mediation process to resolve differences in payment rates. The mediation approach was included in Representative Ruiz's bill, titled "Protecting People from Surprise Medical Bills Act of 2019." Both proposals went through multiple iterations, all ending in gridlock until February of 2020, when two House committees released new bipartisan proposals proclaiming both parties wanted to get something done. The largest hurdle to overcome on both sides of the aisle was how to best resolve payment disputes between insurers and providers.

Nothing much on the issue was heard again until a few weeks ago when on December 21, 2020, Congress voted on the budget omnibus bill to keep the federal government open and provide additional COVID-19 financial relief. But among the bill's more than 6,000 pages, language on surprise medical billing had also been included.

Renamed the "No Surprises Act," the legislation came about after leaders of several House and Senate committees earlier in December rolled out a surprise billing compromise that presented friendlier terms to providers.

The deal, and now the law, fell in favor of providers who wanted an arbitration resolution for out-of-network charges and a loss for payers who endorsed a benchmark rate for such charges.

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Public Policy

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The law now prohibits certain out-of-network providers from balance billing patients unless the patient is notified of their network status. The patient must also receive an estimate of any charges 72 hours prior to getting the out-of-network care.

Out-of-network charges will be based on a negotiation between payers and providers, and claims may be batched together to ease administrative burdens. Each party must submit an offer to an independent arbitrator, who will choose one of the amounts. Chief among the concessions is a prohibition on the arbitrator from factoring in Medicare and Medicaid rates when deciding on an out-of-network charge — a change asked for by the American Hospital Association.

Up to 10 other states have now adopted laws to ban balance billing. In early 2020, Colorado, Texas, New Mexico, and Washington began enforcing balance billing laws. Some states also have a limited approach towards balance billing, including Arizona, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, North Carolina, Pennsylvania, Rhode Island, and Vermont. With a new federal law, states with current surprise billing laws may find their laws strengthened or in conflict with the new federal law, as in California where AB 72 will fall in some conflict with new federal law.

For states with no standing surprise billing law, something that was created by states laws, now through federal law, will be enforceable in their states.

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

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