



## Pain Management in the Crosshairs: A CAP Roundtable, Part 2

**Guests:** Dr. T. John Hsieh, Dr. Medhat Mikhael, Dr. Charles Steinmann, and Dr. Jae Townsend

**Moderator:** Carole A. Lambert, MPA, RN

**We continue the conversation with Dr. Hsieh, Dr. Mikhael, Dr. Townsend and Dr. Steinmann, which we began in the May issue of CAPsules.**

**CAP:** Dr. Hsieh, you have talked in the past about how patients on pain medication long-term are changed. What have you observed?

**TJH:** My experiences with my patients has prompted concerns about the cellular, the metabolic effects of prolonged pain medication administration. If you have ever seen and evaluated a patient who has been on long-term narcotics, your assessment will reveal how

they have changed. Research shows that the changes start at the cellular level and get amplified when you lead up to a whole. The patient's perception of society changes. Daily behavior changes. Rounding out a comprehensive assessment is challenging, but getting one makes it possible for a physician to make a difference with patients. When a patient comes to you saying they want to be treated for his or her pain, educating them about what's happened to them, talking about what their goals are, and managing their expectations will be key.

*continued on page 2*

### Cooperative of American Physicians, Inc. and Mutual Protection Trust Notice of Joint Meeting of Members July 25, 2018

A regular annual meeting of members of the Cooperative of American Physicians, Inc. (CAP), a non-stock membership cooperative corporation, and the members of the Mutual Protection Trust (MPT), an unincorporated interindemnity arrangement, will be held at:

**333 S. Hope St., 8th Floor, Los Angeles, CA 90071  
at 1:00 p.m. on July 25, 2018**

to transact such business as may properly come before the meeting or any adjournment thereof.

The business day prior to the mailing of this notice shall operate as the record date for the determination of those members entitled to notice of the meeting. The Boards will present no items on the agenda for membership vote.

The next election for members of the CAP Board of Directors and MPT Board of Trustees is scheduled for summer 2019.

Paul R. Weber, MD, PhD  
Secretary of the CAP Board of Directors

Andrew Sew Hoy, MD  
Secretary of the MPT Board of Trustees

**MM:** I agree. We have a step-by-step approach. I may evaluate a patient who has not been on narcotics before and feel that this patient is a legitimate patient to be on pain medications whenever needed.

I have to have an agreement with the patient with multiple points: I am the only prescriber. They cannot ask for early refills. They cannot share these medications with anybody. They cannot take medications from anybody else. They are very centered about using one pharmacy only. The prescription comes only from us. They agree to have a random urine screen done on our premises.

We also make sure we obtain informed consent with detailed discussion of possible side effects. We run a CURES report. We manage pain patients in a tight fashion. The patient understands that we are monitoring them closely and that we're working towards treatment approaches to help their pain and get them off medications

**CS:** We've learned some lessons here at CAP that we can carry forward to protect physicians and patients. The first thing is documentation. Whether it's pain management, surgery, or just medical care in general, it may be difficult but it has to be done. Communication is probably the second most important thing, and that comes back to the patient's goals and expectations. For instance, there are a lot of patients who will come in having had chronic back pain for many years and may have had laminectomies. Their pain levels when they come in are an 8/10. We talk about trying to make a goal of 4/10. If we can make a goal of 4, that will be a victory and we talk about that, and 95 percent of the time they'll say if I get it to a 4, okay, I might be able to live with that and that would be a victory. Well, that to me is an achievement and if you get better

than a 4, then you are a super winner and they love you forever. So having expectations that are within reason, using available tools and controls, and effective communication and documentation are very, very important.

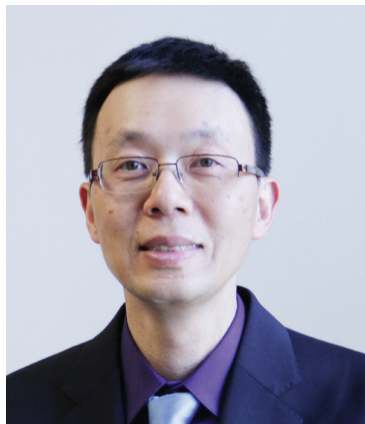
Also, I think a lot of things can be covered without narcotics. I am more and more impressed as time goes on about the use of anti-inflammatories. Certainly, going back to the operative situation and using the anti-inflammatories for certain surgeries, once you know that there's not a bleeding problem, Tramadol has been and is a terrific drug. Toradol is also a terrific drug especially for use with laparoscopes.

Let me just say that we hear there is a drug problem now, as if there wasn't in the past with opium and cocaine. There are a lot of things in motion here, and medicine is still an art, not a science.

**MM:** A big problem with a big impact is that a lot of payers have issues or problems covering behavioral health and addiction treatment. So you get a patient who agrees with your terms, agrees with the plan, and accepts the risks. The patient may be fearful but agrees that they need help. Then you go to the health plan and say, "I need a psychologist to see the patient," or, "I need a psychiatrist to take on that patient because as we get him off narcotics, he's going to be depressed," or, "I need an addictionologist to help me to get him off that stuff he's been on." Then all of a sudden, you find that behavioral health and addiction medicine are not covered benefits for this patient's insurance. It's a challenge for us as clinicians as we try to take care of patients and practice safely.

**CAP:** Dr. Townsend you see people. They have general anesthesia. They come out, they have finished their

*continued on page 3*



Dr. T. John Hsieh



Dr. Medhat Mikhael



Dr. Charles Steinmann



Dr. Jae Townsend

procedure, but you must be interacting with families a great deal. What about the patients who are not on the census — the families?

**JT:** We approach this as a constellation of biopsychosocial spiritual factors. When we treat a child, we don't just treat the child — we treat the child's family, as well as his or her social environment. It is absolutely essential to have everybody on the same page. For children, we get a lot more mileage out of a preventive for pain, and I would say the same is for adults. You know, we talk a lot about pain management, but we need to have lively and abundant conversations about pain prevention. So, we do lots of things in anesthesia such as regional blocks to prevent the experience of pain, so you don't have those apparent pathways that get set up whether it's wide dynamic range neurons or complex regional pain syndrome. These are things that may happen when you have a painful experience that's not prevented or initially managed well.

**TJH:** As chair of CAP's anesthesia/pain management risk assessment peer review, I can say we've learned a lot. I have been doing case reviews for more than 10 years, and I know I am more careful in my own practice. What I have seen over and over is that the number one cause of lawsuits around pain management is failure to manage patients' expectations. Patients' expectations are different from their physicians' expectations. And patients' expectations of pain management physicians are different from their expectations of other physicians. This is where communication in all its forms— education, informed consent, pain contracts – is so important. So when patients feel they haven't had all their questions answered, that the physician has kept information from them, that there's a lack of transparency, then the patients were more likely to file a claim. That's my perception number one.

And my perception number two is the critical importance of documentation. A lot of physicians for one reason or another fail to document what is going on with the patient. They get busy. They forget. For whatever the reason, they fail to document exactly what happened, when it happened. Rarely — and it never ends well — a physician will add to or edit the record. That doesn't happen too often, but we have seen it. So, at the end of the day, document as truthfully as possible, and as carefully as possible.

And finally, when an issue comes up, it's always a good idea to call CAP's hot-line and a talk to a risk management and patient safety specialist. They will give you a very concise and correct pathway for you.

**CS:** That's excellent. I'm glad you brought up the CAP Hotline because that is a unique thing that we do and believe me, it is very very helpful for the clinicians.

**CAP:** We have just a few minutes for final thoughts

**TJH:** Just a caveat for all of us to think about: all of us involved in healthcare — clinicians, entities, systems, industry partners — share the responsibility to work together to reverse the substance use and abuse patterns. This means, among other things, being willing to pay for the professionals, the tools, the alternative treatments. It means being willing to advocate for those resources. No one factor is responsible for the rates of addiction and the rates of death by overdose. No one factor is the answer. Everybody needs to be part of the solution.

**JT:** I just want to dovetail on what was said about documentation. Your record and what you document is what happened. If you didn't write it down, it didn't happen. So as a treating physician for pain patients, it is imperative to always keep a record.

**MM:** I always tell students and young doctors: treat your patients exactly like you're treating your own family members. If you think that way all the time, patients not only will love you and trust you, but your liability will be reduced. Definitely this is in addition to what others have said: document, document, document.

**CAP:** Dr. Tom Nasca, CEO of the Accreditation Council on Graduate Medical Education, said in a presentation a couple of weeks ago, that we are preparing the prescribers of the next 40 years. So everything that we do with the young physicians, young clinicians who come within our orbit, is going to pay off in the future for a more balanced approach.

Dr. Townsend, Dr. Mikhael, Dr. Hsieh, Dr. Steinmann, thank you all so much and I know that folks who listen to this podcast or read about the roundtable are going to be challenged and reassured by everything you've contributed today. 🌸

# Risk Management — and — Patient Safety News



## Telemedicine Risk Management Strategies

Telemedicine is the practice of medicine using electronic communication, information technology, or other means, between a physician in one location and a patient in another location with or without an intervening healthcare provider. With recent advances in the practice of telemedicine, the appropriate application of medical services offers potential benefits in the provision of medical care.

These technologies, when utilized properly, can enhance medical care by facilitating communication between patients and their physicians or other healthcare providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing healthcare information, and clarifying medical advice.

It is important for CAP members who wish to expand their practice to include telemedicine to contact CAP Membership Services to verify coverage. Once approved, the member should follow the guidelines, listed below from Risk Management, to maintain a risk-adverse telemedicine practice.

### Physician-Patient Relationship

A physician-patient relationship must be established through, at minimum, a face-to-face examination, if a face-to-face appointment would otherwise be required in the delivery of the same service not provided via telemedicine.

A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without:

1. Fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;

2. Disclosing the validation of the provider's identity and applicable credential(s); and
3. Obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special consents regarding the use of telemedicine technologies.

### Documentation

The California Legislature has expressed its intent that all medical information transmitted during the delivery of healthcare via telemedicine become part of the patient's medical record. In addition, the consent must be documented in the medical record as well.

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contraindications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise.

All patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies must be documented.

### Privacy and Security/HIPAA

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules.

June 2018



## Risk Management Strategies

- Provide the CAP telemedicine documents entitled “What Is Telemedicine?” and “Consent to Use Telemedicine” to the patient and receive the original executed and dated forms from the patient for the patient medical file. Visit the CAP website to download both documents listed under “All Practice Forms” - <https://www.capphysicians.com/risk-management/tools-and-resources>.
- Verify and authenticate, at each encounter, the patient’s identity and location.
- Verify, at each encounter, the patient’s readiness to proceed in a setting that is private and conducive to uninterrupted communication.
- Obtain appropriate consents.
- Document all medical information transmitted during the delivery of healthcare via telemedicine in the patient’s medical record.
- Meet or exceed HIPAA and state privacy and confidentiality laws.

If you are a CAP member planning to start a telemedicine practice, it is important to contact CAP’s Membership Services Department (800-610-6642) to discuss coverage and special instructions. ➔

### References:

California Telehealth Resource Center  
[www.caltrc.org](http://www.caltrc.org)

Medical Board of California: Practicing Medicine Through Telehealth Technology  
[www.mbc.ca.gov/Licensees/Telehealth.aspx](http://www.mbc.ca.gov/Licensees/Telehealth.aspx)

American Telemedicine Associations  
[www.americantelemed.org](http://www.americantelemed.org)

Center for Telehealth and eHealth Law (Ctel)  
<http://ctel.org>

Health Insurance Portability and Availability Act  
[www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)



# Legislative Focus on Pricing Continues

by Gabriela Villanueva

Intended to end “surprise medical bills” for consumers, Health and Safety Code Section 1371.30 became effective on July 1, 2017, following Governor Brown’s signature on AB 72 in the 2016 session. The new law has imposed additional balance-billing prohibitions on “non-contracted” physicians beyond the longstanding balance-billing prohibition for emergency services. An additional section of the code, Section 1371.9, requires health plans and insurance companies to inform non-contracted physicians of the “in-network cost sharing amount” for which patients are responsible and establishes an independent dispute resolution process to determine the amount health plans and insurance companies must pay non-contracted physicians.

Substantial opposition to the bill, carried by Assembly Member Rob Bonta (D-Alameda), came from both national and state specialty societies and associations, including the Association of American Physicians and Surgeons, Inc. (AAPS), which strongly encouraged the Governor to veto the bill. AAPS argued that AB 72 was flawed because of its threat to access to healthcare and in a letter pointed out that it “would essentially allow private insurance companies to fix the reimbursement rates for all physicians, even including physicians who are not in-network or under contract with the insurance companies.” The association added that “this legislation prevents a physician from obtaining adjustments in the rates that may be necessary for the physician to stay in practice, or to obtain a reasonable fee for the services provided . . . The victims of these price controls have no procedure for challenging the rates, other than a one-by-one piecemeal arbitration process that has proven to be unfair. . . .”

The comments on AB 72 in 2016 sound familiar as price-setting for medical services and procedures was again on the Legislature’s mind with AB 3087, a bill introduced this past March by Assembly Member Ash Karla (D-San Jose). AB 3087 was a far more encompassing bill intended to set pricing for healthcare services and procedures via the establishment of a commission. AB 3087 received intense opposition from the healthcare and business communities and failed to proceed out of committee.

After implementation of AB 72 in July 2017, the California Medical Association began receiving calls from physician offices with questions over payments

by several major health insurance providers. Section 1371.30 requires fully insured commercial plans and insurers to make “interim payments” to non-contracted physicians for covered, non-emergent services performed at in-network health facilities. The interim rate is defined as the greater of the average contracted rate or 125 percent of the amount that Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic region in which the services were rendered.

CMA says it worked with Blue Shield to ensure affected claims through October of 2017 were automatically reprocessed and that the provider has committed to conducting weekly audits to catch any additional claims that were incorrectly processed. While Blue Shield continues to process claims manually, it expects to implement an automated system fix by mid-year, according to CMA. Anthem, another major provider, has reported to the Department of Managed Health Care that it implemented a system fix to allow claims subject to Section 1371.30 to be processed automatically rather than manually, according to the CMA.

Physicians who receive incorrect payments or denied claims related to new Section 1371.30 may contact CMA’s AB 72 advocate, Juli Reavis, at 888-401-5911 or [jreavis@cmanet.org](mailto:jreavis@cmanet.org). ↩

*Gabriela Villanueva is CAP’s Public Affairs Analyst. Questions or comments related to this article should be directed to [gvillanueva@CAPphysicians.com](mailto:gvillanueva@CAPphysicians.com).*



# 3 Ways Unhappy Patients Can Get You in Trouble

## And How CAP Can Help Mitigate These Risks

Like many physicians, you may be burdened with administrative obligations that can make it difficult to balance outstanding clinical care with excellent customer service. But both play a critical role in the success of your practice.

Patients who are displeased with the care or professionalism they receive from you or a staff member can react in a number of detrimental ways, including posting **negative online reviews, leaving your practice or – worst-case scenario – filing a malpractice claim.** As part of CAP's commitment to protecting you and your practice, we offer a number of benefits designed to help improve the patient experience and optimize practice success.

Below, you'll find three critical issues that can result from patient dissatisfaction, along with solutions from CAP-vetted vendors that can help rectify each – at discounted member rates:

**Issue:** Lawsuits Stemming from Miscommunication or Lack of Informed Consent

**Solution:** *Medical Memory* Video Patient Engagement Solution

Medical Memory was created to bridge the gap between doctor and patient communication. This gap in patient understanding can often lead to poor patient compliance, a greater risk for hospital readmission, and increased liability for medical malpractice claims. Medical Memory enables you to:

- **Capture** valuable medical information exchanged during a patient consultation
- **Highlight** specific details on X-rays, models, and scans that will provide patients with a better understanding of their condition
- **Give** patients access to video recordings of office visits through a secure and password-protected portal where they can review their video and share with loved ones

Not only can Medical Memory help mitigate risk, but it can also save you time by reducing the number of follow-up phone calls from patients, because most questions are answered during their clinical visit.

**Issue:** Tarnished Online Reputation

**Solution:** *PatientPop* Online Marketing and Reputation Platform

PatientPop makes it easy for patients to share feedback with you and tell others about their positive experiences. To ensure top-tier healthcare reputation management, PatientPop helps monitor your reviews from external review sites every week, alerting you of negative feedback and pulling positive testimonials for use on your practice website.

In addition to helping preserve your professional reputation, PatientPop offers practices a suite of services to help grow your practice, including website development, online scheduling, social media support, and much more.

**Issue:** Reduced or Delayed Reimbursement

**Solution:** Patient Experience Survey Program (PESP)

Through our relationship with SE Healthcare, physician members can implement a cost-effective, high-performance online survey platform that – among many other practice-optimization functions – generates a detailed patient experience analysis.

**The data collected leads to actionable insights and answers to your questions to allow you to make improvements and maximize your earnings through optimized reimbursement from payer negotiations.** ➡

For more information about any of these discounted programs designed to help foster increased patient satisfaction, and an improved bottom line...

**call** 888-645-7237 or

**email** CAPAdvantage@CAPphysicians.com.

# Case of the Month

by Gordon Ownby



## Patient's Aggressive Choice Could Remove a Diagnostic Safety Net

When reporting their findings, it is common to see consulting physicians recommend further testing. Absent such an explicit recommendation, a patient's decision to bypass conservative measures can spell trouble for all.

When a diagnostic mammogram on a 57-year-old woman with no family history of breast cancer identified a suspicious abnormality on the left breast, the patient's primary care physician, Dr. PC, referred her for a core biopsy. Dr. P, a pathologist, diagnosed a left breast invasive ductal carcinoma. Dr. P assigned a provision grade of "II/III" and noted that "histologic grading is provisional owing to the limited sampling inherent in needle core biopsies. This may change when the entire lesion is evaluated." Dr. P's report made no other references regarding further tests to confirm cancer. Dr. C, the clinician performing the needle core biopsy, cited Dr. P's diagnosis in the addendum to his report on the procedure and also wrote: "Suggest MRI, to see the extent and additional disease. Then referral to breast surgeon."

Impressions from the subsequent bilateral MRI ordered by Dr. PC included a normal right breast and a "known solitary malignancy" in the left breast. The radiologist included in her recommendations: "The patient is a candidate for a wire localized lumpectomy. I would have her follow up with her breast surgeon."

The patient visited a surgeon, Dr. S, 10 days later and discussed surgical options, including a lumpectomy and nipple-saving mastectomy. Before deciding anything, the patient consulted with a plastic surgeon and a genetics counselor. Though when she returned to Dr. S several weeks later the results of genetics testing

were not yet available, and the patient told the surgeon that she wanted a double mastectomy, rejecting a local wire lumpectomy.

Surgery some two weeks later included bilateral nipple-saving mastectomy and left sentinel node biopsy by Dr. S and breast reconstruction with tissue expanders by a plastic surgeon. The surgical pathology report, however, showed no cancer in the removed tissue or lymph node. As for the left breast, the post-surgical report described findings of multinodular adenomyoepithelioma and atypical ductal hyperplasia. A second review performed at a university hospital confirmed the absence of carcinoma. Results of genetic testing returned several weeks later showed no BRCA mutations.

When Dr. S subsequently sent the original core biopsy to the university hospital for a new read, the pathologist there commented on a differential diagnosis of adenomyoepithelioma: "Imaging and clinical correlation is advised. Recommend performing IHC markers such as P63, Calponin, and SMMHC to confirm diagnosis of adenomyoepithelioma."

The patient sued Dr. P, alleging that a misdiagnosis resulted in the loss of her breasts. The legal matter was resolved informally.

In many cases alleging a medical error, a subsequent reading of the record will reveal opportunities for avoiding a bad result. In this case, a lumpectomy option, as described in the MRI report and discussed by Dr. S, stands out. Even earlier in the record, Dr. P's comment on getting a more accurate histological grade "when the entire lesion is evaluated" — was apparently

June 2018



not focused enough to trigger the patient's other providers to pursue further tests.

Given the patient's desire to pursue her most aggressive option — the double mastectomy — no one will know if an explicit recommendation in Dr. P's report for further tests would have put the patient's care on a different

course. But without such qualifications, the report ended up shouldering a big responsibility. ⚡

*Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to [gownby@CAPphysicians.com](mailto:gownby@CAPphysicians.com).*

## Important Legislative Update on Coverage Waiver Requirements for Workers' Compensation

### Read to See if This Impacts You

**Effective July 1, 2018, the California Legislature, under Senate Bill 189, will broaden the criteria for owners in some entity types to be eligible for exclusion on new and renewal policies.**

Currently, under AB 2883, an individual officer/director must own at least 15 percent of a corporation's stock, be a general partner in a partnership, or be a managing member of a Limited Liability Company (LLC) in order to be eligible for exclusion from a workers' compensation insurance policy.

#### **Under the new SB 189:**

- **Partnerships and LLC** – The general partners' or managing members' ownership interest may now be held in a revocable trust.
- **Corporations** – The ownership threshold for waiving workers' compensation coverage was amended from 15 percent to 10 percent and shares may now be held in a revocable trust.

In addition, this bill includes specific waiving provisions for professional corporations, cooperative corporations, and closely held family businesses.

#### **What You Need to Do**

No action is required where policyholders have already returned all applicable waiver of coverage forms under existing law and there are no changes in the structure.

Action is required when owners who are now eligible under SB 189 would like to elect exclusion on their policy incepting July 1, 2018, and forward. Your workers'



compensation insurance carrier will be sending you the required waiver form. In order to be excluded from the policy, you are required to complete the form with the insured name and policy number completed. The person to be excluded must sign and return it to the insurance company.

Be sure to keep a copy of the completed form for your records. **State law does not allow the insurance company to backdate the waiver form.**

CAP Physicians Insurance Agency is happy to send you a copy of the waiver form. Simply call 800-819-0061 or email [CAPAgency@CAPphysicians.com](mailto:CAPAgency@CAPphysicians.com). ⚡



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## IN THIS ISSUE

- 1 Pain Management in the Crosshairs: A CAP Roundtable, Part 2
- 1 Cooperative of American Physicians, Inc. and Mutual Protection Trust  
Notice of Joint Meeting of Members July 25, 2018
- 4 Risk Management and Patient Safety News:  
*Telemedicine Risk Management Strategies*
- 6 Public Policy:  
*Legislative Focus on Pricing Continues*
- 7 3 Ways Unhappy Patients Can Get You in Trouble  
And How CAP Can Help Mitigate These Risks
- 8 Case of the Month:  
*Patient's Aggressive Choice Could Remove a Diagnostic Safety Net*
- 9 Important Legislative Update on Coverage Waiver  
Requirements for Workers' Compensation

June 2018

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