Can Compliance Teach Physicians to Comply?
Adapting Different Healthcare Models to Teach Physicians Compliance

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Speakers’ Disclaimer

- Richard E. Moses, DO, JD and D. Scott Jones, CHC do not have any financial conflicts to disclose.
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Presentation Goals

- Understand the evolving healthcare system as it relates to physicians and providers
- Understand how to approach educating physicians about compliance concepts
- Learn how to develop a compliance education program for healthcare providers
- Analyze and discuss compliance teaching problems

INTRODUCTION
INTRODUCTION

- Demands on the System
- About Physicians
- Analyzing Your Healthcare Facility and Its Resources
- Education Opportunities
- Curriculum Process: Deciding What to Teach
- Education Program Workshop
- Conclusions

DEMANDS ON THE SYSTEM
BACKGROUND

- Old Risk Model
  - Medical Malpractice
  - General Liability

- New Risk Model
  - Medical Malpractice + Risk Management
  - Regulatory Compliance
  - Quality Management

Conventional Thinking:
Healthcare Risk Silos
Healthcare Compliance Reality: Overlapping Circles of Risk

Demands: Major Intersection

- Healthcare Reform Goals
  - Improve Access
  - Universal Coverage
  - Increase quality reporting to include outcomes for reimbursement
  - Increase integration of care through partnerships of physician networks & hospitals
  - Cost control & cost reduction
- Government is focused on reducing “unnecessary” medical costs
Demands on the System

- Public Perception of Quality Concerns
- Increased Government Oversight
- Physician Shortage
- Loss of Private Practice Medicine
- Nonphysician Clinician Care
- Nursing Shortage
- Increased Volume of Patients
- Decreasing Reimbursement
- Aggressive Plaintiff Attorneys

Physician reimbursement declined 25% (1995-2008)
Patient Protection and Affordable Care Act (PPACA 2010) amended by the Health Care and Education Affordability Reconciliation Act (HCERA 2012)
  - 21.3% scheduled reduction in Medicare physician pay (postponed by the Continuing Extension Act of 2010)
  - Quality and Cost Payment (Title III, §§ 3002, 3003, 3007) – Adjusts physician payments based on quality and cost through a value-based modifier, beginning January 1, 2015
  - PQRI – possible penalties for not reporting beginning in 2015 up to 2% of the prevailing fee schedule
Demands on the System

- Legally limited ability of independent practices to jointly negotiate for higher fees from payors
- Anti-Kickback Statute and Stark Law restrictions on ancillary services ownership and referrals
- Increased regulatory pressure: RC Audits, HIPAA requirements, CMS and OIG investigations, OSHA
- Demand for a highly efficient business model with carefully managed overhead costs

Demands on the System

- Increase from 260.2 Million Americans with health insurance to 292.6 Million under PPACA
- 32 Million Americans may acquire new health insurance with PPACA
- U.S. physician workload expected to increase by 29% from 2005-2025
- Almost 50% of physicians are health system employees
Demands on the System

PPACA: The Future is Now

- 32M+ beneficiaries nationwide (January 1, 2014)
- National Bureau of Economic Research: Individuals receiving Social Security benefits for the first time see physicians an average of 8 times per year, from ages 65-69

www.nber.org/chapters/c9857.pdf

Demands on the System

PPACA: The Future is Now

- 8 visits per year $\times$ 32M = 256,000,000 healthcare visits
- 256,000,000 healthcare visits = 256,000,000 new medical records, documentation entries by primary and specialist doctors, plus referral visits, diagnostic tests and billings

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Demands on the System

Physician Availability

- American Medical Association:
  National Physician Shortage = 91,000 by 2020\(^1\)
- Physician Foundation Survey (2012)\(^2\)
  - 50% of physicians employed by health systems
  - Up to 75% contemplate employment
  - Employed physicians work 5.9 hours less per week
    - FTE loss of 44,250 doctors
  - Physicians spend 22% of their time on administrative paperwork & EMR
    - FTE loss of 165,000 doctors
- Total Physician Shortage = 300,250 doctors\(^2\)

1. www.ama.org
2. www.physicianfoundation.org

ABOUT PHYSICIANS
“No college junior studies organic chemistry and takes the MCAT planning to devote 4 years to medical school and 3 plus years to residency and fellowship just to cheat Medicare and Medicaid.”

Julie K. Taitsman, M.D., J.D.
CMO for the OIG, Department of HHS

About Doctors in General

- Main Goal: Deliver quality care in an effective safe manner
- Competitive, OCD, delayed gratification & clinical
- Tend to be detailed overachievers and/or survivors
- Clueless about Compliance!
About Doctors in General

- Think in terms of medical malpractice avoidance
- No prior training about fraud, abuse, &/or medical malpractice
- Inherently do not like or trust administrators
- Some people are just crooks...doctors included!

ANALYZING YOUR HEALTHCARE FACILITY & ITS RESOURCES
Approaching Physician Education

- One size does not fit all programs
- Each organization has unique needs
- One teaching method alone is not enough
- Areas of malpractice & compliance risks evolve and change with time
- A “check off” approach to physician education does not work
- You catch more flies with honey that you do with vinegar...PARTNER WITH YOUR DOCS!

Things to Consider

- What is your health system model?
  - Academic v. Private Practice
  - Mixed/hybrid
  - ACO v. other

- What is the physician relationship with the health system?
  - Employment contract
  - Private
Things to Consider

- Where are you to date with Compliance education?
- Size of practice to be educated
- Physical location of practices
- Method(s) & venue of physician education
- Education is continuous; not a one shot deal!

Things to Consider

- Relevant & necessary topics
  - Provide education required by law first; then everything else
  - OIG Work Plan
  - Areas of risk that have internally or externally surfaced
- Allowable time - Time is money to physicians
- Budget
Teaching Principles

• Helpful & supportive approach
• Teamwork philosophy
• Avoid intimidation
• Request feedback, review it, act on it!

Teaching Principles

• Positive attitude – compliment & encourage
• Explain topic background & reference
• Engage physicians to share experiences
• Avoid confrontation with physicians, et al
Teaching Principles: An Administrator and Compliance Officer’s Perspective

- Physicians are taught to assess, diagnose, implement correct treatment action, and be responsible for outcomes
- Little tolerance for ambiguity
- As scientists, respect facts and data that can be supported by research

Teaching Principles: An Administrator and Compliance Officer’s Perspective

- Understand but often dislike Peer Review
- Dislike being outliers
- Dislike being embarrassed before peers
- Generally want to do the right thing → What is it?
EDUCATION OPPORTUNITIES

HITECH & Doctors

- **What is a Breach?**
  - Acquisition, access, use or disclosure of PHI
  - Compromises the security or privacy of the protected health information

- **Duty to provide notice to patients**
  - “A covered entity shall, following the discovery of a breach of unsecured PHI, notify each individual whose unsecured PHI has been, or is reasonably believed by the covered entity to have been, accessed, acquired, used, or disclosed as a result of such breach.” (45 C.F.R § 164.404)
HIPAA Data Breach and EMR

HHS Office for Civil Rights (OCR)

Breach Notification Highlights

500+ Breaches by Type of Breach

HHS Office for Civil Rights
Areas of Quality Risk Exposure

• Physician-Patient Communication
• Lack of Medical Necessity for Performed Medical Services
• Improper Performance of Medical Services/Care (Medical Decision Making)

Areas of Quality Risk Exposure

• EMR /Medical Record Documentation
• Informed Consent Deficiencies
• Inadequate Patient Education
Quality of Care
Office of the Inspector General Work Plan

- Over Utilization i.e., coding E&M services
- E&M Services during global services
- Cloned Notes in EHR E&M services
- Modifier use
- “Not medically necessary” services

Top Malpractice Allegations/Quality Exposures
All Medical Specialties

1) Improper Performance Medical Care
2) Errors in Diagnosis
3) Failure to Supervise/Monitor medical cases
4) Medication Errors
Top Malpractice Allegations/Quality Exposures
All Medical Specialties

5) Failure to Recognize Complications
6) Treatment Performed when Contraindicated
7) Necessary Treatment Not Performed
8) Delay in Performance
9) Failure to Instruct/Communicate with Patient

Physician Insurers Association of America 2010, 2011

PIAA Risk Management Data
Most Prevalent Medical Misadventures: Combined Specialties

<table>
<thead>
<tr>
<th>Medical Misadventure</th>
<th>Paid Claims</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper Performance</td>
<td>657</td>
<td>$187,874,743</td>
<td>$285,959</td>
</tr>
<tr>
<td>Errors in Diagnosis</td>
<td>561</td>
<td>$226,244,302</td>
<td>$403,288</td>
</tr>
<tr>
<td>Failure to Monitor</td>
<td>202</td>
<td>$73,212,196</td>
<td>$362,437</td>
</tr>
<tr>
<td>Failure to recognize complication</td>
<td>220</td>
<td>$80,615,092</td>
<td>$366,432</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>85</td>
<td>$19,869,854</td>
<td>$233,763</td>
</tr>
<tr>
<td>Failure to instruct or communicate with pt</td>
<td>43</td>
<td>$9,689,866</td>
<td>$225,346</td>
</tr>
<tr>
<td>Delay in Performance</td>
<td>73</td>
<td>$41,823,407</td>
<td>$572,923</td>
</tr>
<tr>
<td>Not Performed</td>
<td>58</td>
<td>$22,009,689</td>
<td>$379,477</td>
</tr>
</tbody>
</table>

Physician Insurers Association of America 2010
National Practitioner’s Data Bank (NPDB)

- Medical malpractice payments
- Adverse licensure and certification actions
- Adverse clinical privilege actions
- Adverse professional society membership actions
- Health care-related criminal convictions and civil judgments and other adjudicated actions
- Medicare/Medicaid exclusions
- Other adjudicated actions against practitioners, providers, and suppliers
- Any negative action or finding against a health care practitioner or entity

Medical Error Disclosure
Are medical errors frequent?

- 1 in 13 persons experience an undesirable medical event
- 7.5% of patients hospitalized for a short time suffer harm of some kind
  - Ladouceur, R. Owning up to medical errors, Can Fam Physician 2007;53:201 (February)
How do Physicians respond to errors?

- 75% of Physicians think disclosure will reduce the likelihood of a lawsuit
- Only 30% of patients involved say their Physician informed them of the error

Medical Error Disclosure Results

- 98% of patients want acknowledgement of even minor errors
- 14% will ask to be referred to another Physician for a minor mistake
- 65% will ask to be referred for a severe mistake
- 88% will not sue if the Physician admits a mistake
- 20% will sue if the Physician fails to admit a mistake and the patient later learns about it

NEJM 2007;356:2713-2719
Cascade of Errors

- A “Chain of Errors” occurs in 77% of injury incidents
- 80% of cases include miscommunication
  - 44% communication breakdowns with patients or colleagues
  - 21% misinformation in the medical record
  - 18% mishandling patient requests and messages
  - 12% inaccessible medical records
  - 5% inadequate reminder systems
- Physicians answered that harm occurred in only 43% of cases in which narratives described harm

Systemic Protections and Requirements

- 49 States have established Peer Review Privileges under State Law (New Jersey excepted)
- 27 states prohibit introduction of Physician apologies as admission of guilt in medical malpractice cases
- Typical Standard: “Notify patient...or family when outcome....differs significantly from an anticipated outcome”
- 39 States (and growing) have a mandatory serious event reporting program
National Protections

- Patient Safety and Quality Improvement Act of 2005
  - Federal Law prohibits employers and healthcare organizations from taking action against healthcare providers who disclose errors, except in cases where the law may have been broken.

How to Disclose Medical Errors?

- Hospital Risk Management
- Malpractice provider
- Have an Error Disclosure Plan in advance
- Remember: “A stiff apology is a second insult.... The injured party does not want to be compensated because he has been wronged; he wants to be healed because he has been hurt.”
  - Gilbert Keith Chesterton
Compliance and Quality Investigations

Quality of Care Investigation

- St. Josephs’ Medical Center, Baltimore, MD opens new, state of the art Cardiac Catheterization Laboratory in 2008.
- 1/2008: Retains leading NE area interventional cardiologist, Mark Midei, MD as Director.
- Cath Lab quickly becomes the “go to” facility for difficult cases and stent placement.
- Stent utilization exceeds all manufacturer’s prior records, according to e-mail messages by manufacturer later discovered during investigation → over 1000 stents are placed in 2008.
Quality of Care Investigation

- 11/08 & 4/09: In two letters, staff complain to the State Board of Physicians of 36 & 41 patients with “unnecessary stents.”
- 4/09: Hospital employee who had a stent placed files a *qui tam* complaint with the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) complaining they received a stent that was not medically necessary. DHHS joins suit.
- 6/09: OIG begins a civil investigation.

Quality of Care Investigation

- 4/09 to 6/09: 658 stent placements are reviewed as “not medically necessary.”
- 4/09 to 6/09: Hospital relieves Dr. Midei, and eventually the CEO, CFO & other administrative staff.
- 10/09 to 2/10: Letters are sent advising patients to consult with their Cardiologist because of unnecessary stents.
Quality of Care Investigation

- 2/10: Dr. Midei is the subject of a highly publicized U.S. Senate Finance Committee investigation.
- 11/10: Hospital settles the OIG’s charges for $22M and enters a Corporate Integrity Agreement (CIA).
- 7/11: Dr. Midei’s license to practice medicine is revoked by the State Board of Medicine.
- 10/09 to present: Hundreds of medical malpractice lawsuits are filed against Dr. Midei.

Quality of Care Investigation

- 12/09 to present: A media frenzy is ignited, with repetitive, negative news stories about Dr. Midei, the hospital, and parent company, Catholic Health Initiatives.
- 3/12: St. Josephs’ Hospital announces sale to the University of Maryland Medical System. Patient utilization is at record lows. The Cath Lab is virtually closed.
- The first “unnecessary stent” suits brought are about to reach circuit court. To date, plaintiff’s counsel have settled most cases before trial.
CURRICULUM PROCESS: DECIDING WHAT TO TEACH

Areas of Risk Exposure

- Medical record documentation
- Informed consent deficiencies
- Inadequate patient education
- Poor physician-patient communication
- Poor physician-physician/nurse communication
- Lack of medical necessity for performed services
- Improper performance of medical services/care
Areas of Risk Exposure

- Overutilization or unusual utilization of E&M coding
- Cloning notes (OIG) v. copy/paste notes (Medical Malpractice)
- Coding engine dependence
- Modifier use
- “Not medically necessary” services
- Documentation deficiencies
- OIG Work Plan

Educational Resources

- “A Roadmap for New Physicians: Avoiding Medicare & Medicaid Fraud & Abuse”
  - Booklet & companion slide presentation
  - www.oig.hhs.gov/fraud/PhysicianEducation
- Internally Produced v. Commercial CME Programs
- Agency for Healthcare Research & Quality
- Medscape Education
EDUCATION PROGRAM WORKSHOP

EHR LIABILITY ISSUES (EXCERPT)
EHR LIABILITY ISSUES

EHR Liability Issues

- Cloning/Cut & Paste
- Did/did not perform
  - Dropdowns, templates, defaults, macros
- Pre-populated templates
- Voice recognition issues
EHR Liability Issues

- Failure to check all areas of program for results
  - Scanned data v. direct drop
- Improper scanning by support staff
- Failure to check “paper chart” or “scanned chart”
- Changing the note
- Locking the note

EHR Liability Issues

- Chart inconsistencies
  - History
  - Exam
- Failure to read office visit notes created
- Automatic acceptance of coding engine recommendation
- Automatic acceptance of modifier recommendation
REAL TIME EHR PROBLEMS & PROVIDERS

Paper Days

If it’s not documented, you didn’t do it!
EHR Days

You documented it...did you do it?

Surgical Mystery
Where’s the HPI?

Reason for Appointment
1. Prior Visit

Vital Signs
BP: 120/74 mmHg, HR: 81 bpm, RR: 8, HR: 95, BMI: 25.75

Physical Examination

General Observation:
- **GENERAL APPEARANCE:** in no acute distress, well developed, normoactive, cooperative, alert
- **EYE:** normal, alert, non-tearful, consensual reaction
- **EARS:** normal, no drainage, no asymmetry
- **NOSE:** normal, no drainage, no asymmetry
- **THROAT:** normal, no asymmetry
- **ORAL CAVITY:** normal, no drainage, no asymmetry
- **HEART:** normal, no palpitations, no murmurs, no gallop
- **LUNGS:** normal, clear, no expectoration bilaterally, no wheeze, rales, rhonchi

Chest:
- no spider angiomas, no pulsatile nodes. **AP** diameter normal

Abdomen:
- normal bowel sounds present, soft, non-tender, no distention, no masses palpable, no hernias present, no ascites
- no abdominal mass palpable, no guarding or rigidity, no masses, no rebound tenderness, no fluid waves, no ascites, no masses.
- **ROTA:** not assessed
- **RECT:** normal

Neurological:
- alert and oriented, oriented, no diplopia, no syncope, no aphasia, no anomaly.

Vascular:
- Thin weight down to 3 lbs.

Assessments:
1. Oxygen saturation: 97%
2. Carotids palpable: no tenderness
3. Radiation intensity: 3.8
4. History of cervical cancer - yes
5. Physical characteristics:
   - 60"
   - 160 lbs
6. **Vital signs:**
   - BP: 120/74
   - HR: 81 bpm
   - RR: 8
   - Weight: 150 lbs
   - BMI: 25.75

Where’s the appropriate exam?

**Physical Examination**

- **General:**
  - Integumentary
  - Neuro-pyschiatric
  - Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient's mood and affect are described as - normal.
  - Assessments & Plans

- **Hematological:** (23:2)
  - Integumentary
  - Neuro-pyschiatric
  - Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient's mood and affect are described as - normal.
  - Assessments & Plans

- **Cardiovascular:** (26:7)
  - Integumentary
  - Neuro-pyschiatric
  - Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient's mood and affect are described as - normal.
  - Assessments & Plans

- **Dyspnea:** (26:5)
  - Integumentary
  - Neuro-pyschiatric
  - Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient's mood and affect are described as - normal.
  - Assessments & Plans

- **Pulmonary Pain:** (6:5)
  - Integumentary
  - Neuro-pyschiatric
  - Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient's mood and affect are described as - normal.
  - Assessments & Plans
To Tattoo or Not to Tattoo

**Physical Examination**

**General Appearance:** in no acute distress, well developed, well nourished.

**HEAD:** normocephalic, atraumatic.

**EYES:** sclera non-ticotic, conjunctiva clear.

**ORAL CAVITY:** mucous moist, good dentition, no pallor.

**THORAX:** clear.

**NECK:** supple, full range of motion, no cervical (impalpable) lymphatic.

**SADDLEBONE:** (CHEST, LUMBAR, RIBS): warm and dry, no pulsation.

**RESPIRATIONS:** regular @ 16/min. S, Ss normal, no ronchi, no, rhonchi.

**LUNGS:** clear to auscultation bilaterally, no wheeze, no, rhonchi.

**CHEST:** no palpable egophones, no palpable nodes, AP diameter normal.

**HISTORY**

**Reasons to Tattoo:**

- Artistic expression
- Cultural significance
- Medical use (e.g., for identification in times of crisis)

**Reasons Not to Tattoo:**

- einzug in the work environment
- Certain medical conditions (e.g., skin allergies)
- Personal or religious beliefs

**Special History**

**Drug History:**

- Have you used drugs other than those for medical reasons in the past or recently? No.

**Family History:**

- Any family history of medical conditions? Yes.

**Social History:**

- Marital status: Married
- Occupation: Office worker
- Allergies: N/A

**GI Procedures**

- Colonoscopy

**Review of Systems**

- No remarkable findings
To Tattoo or Not to Tattoo

Voice Recognition Error

4. Chronic constipation
Police will continue with habits he's a fiber and stool softeners as needed. Her constipation symptoms for the most part are well controlled at this time.

Vision Loss
Elyse has lost a few more pounds in the last 2 months. I've encouraged her to eat smaller meals throughout the day and use some nutritional supplements. Her BMI is acceptable, but I would not like any more. She did an endoscopic ultrasound on June 4, 2012. Done at Jefferson hospital. The gastric wall was normal as was the pancreas. We'll continue to follow her weight.

Follow Up
4 Months
RISK MANAGEMENT STRATEGIES

Risk Management Strategies

- Develop a process to use EHRs to evaluate patients
- Be careful
- Take your time
- Read what you typed, dictated &/or clicked
Risk Management Strategies

- Check all dates on chart documents
  - Compare with date of last office visit or procedure
- Do not blithely accept E&M level from coding engine
- Use a fax cover sheet with disclaimer
- Stay in contact with administration & leadership re: time demands and necessary support

- Stay in contact with IT and trainers &/or super users
- Cooperate and support the Compliance Team
- Offer and take constructive criticism
- Data Breach & Audit insurance
- DO NOT FORGET THE PATIENT
SUMMARY & CONCLUSIONS

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- Leads a team managing over 700 malpractice claims
- Compliance, Risk and Claims for 3600 providers
- Former medical practice & hospital administrator
- Board Certified Healthcare Compliance Officer (CHC)
- Author, 12 nationally published books and over 50 articles on quality, practice management, and regulatory compliance
- Frequent speaker to state, regional and national organizations
- Over 1000 risk assessment service visits to healthcare organizations nationwide

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Thank You

Health Care Compliance Association
17th Annual COMPLIANCE INSTITUTE
Gaylord National Harbor, MD
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