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- D. Scott Jones, CHC and Richard E. Moses, DO, JD do not have any financial conflicts to disclose.
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- The speakers are not promoting any service or product.

Overview

- Background: Why Reform Health Care?
- Top 10 Risks of Physician Compliance
- Approaching the Problems: Educational Approach
- Summary & Conclusions
BACKGROUND

WHY REFORM HEALTHCARE?
COST Drives U.S. Healthcare Reform


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PPACA and Healthcare Reform

• PPACA
  • Outcome-based payment → PQRS PFS Adjustments
  • Reimbursement shift to incentivize outpatient settings → Readmissions Rule
  • Increasing number of insured patients nationally → Health Exchange Enrollment
  • Goal of improving the overall patient experience → CG CAHPS

Health Affairs October 11, 2012
www.aamc.org/newsroom/newsreleases/2010/150570/100930.html
www.physiciansfoundation.org
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PPACA and Healthcare Reform

• PPACA
  • Competition and publication of outcome and total value → CMS Payment Date, Physician Compare
  • Increasingly independent roles for Non-Physician Clinicians → State by state changes toward independent practice
  • Increased physician employment by health systems → > 60%
    Nationwide (2015)
  • Physician shortage → 130,600 physicians by 2025

Health Affairs October 11, 2012
www.aamc.org/newsroom/newsreleases/2010/150570/100930.html
www.physiciansfoundation.org
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SGR Fix and Healthcare Reform

• The SGR Repeal and Medical Provider Payment Modernization Act of 2015 (HR 1470)
  • Directs the Secretary of Health and Human Services to:
    • Establish a Merit-based Incentive Payment (MIP) system under which eligible professionals shall receive annual payment increases or decreases based on their performance.
    • Draft a plan for development of quality measures to assess professionals, including non-patient-facing professionals
  • MIPS will bring PQRS, Physician Compare, CG-CAHPS, and other measures together in one Value-Based Modifier (VM) reimbursement system in 2018
    • Physicians will continue to comply with current PQRS and VBP systems 2016-2018

Health Care Reform

President Obama Signs MACRA
April 16, 2015
MACRA and Healthcare Reform

• Medicare Access and CHIP Reauthorization Act (MACRA), P.L. 114-10
• $39.5 billion in savings over 10 years
• Section 101: Repeals Medicare Sustainable Growth Rate (SGR)
  • Institutes the Merit-Based Incentive Payment System (MIPS)
• Section 201: Extend the 1.0 floor on the Physician Work Geographic Practice Cost Index (GPCI) until January 1, 2018

MACRA and Healthcare Reform

• Section 204: Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals
• Section 402: Income-related Premium Adjustment for Parts B and D beneficiaries
• Section 412: Delay of Reduction to Medicaid DSH Allotments to 2025
• Section 414: Adjustments to Inpatient Hospital Payment Rates
• Section 521: Extension of Two-Midnight Rule on Certain Medical Review Activities
MIPS Clinical Practice Improvement Examples

- Expanded practice access
  - Same day appointments for urgent needs
  - After hours access to clinician advice
- Population management
  - Ongoing monitoring of health conditions of individuals
  - Timely health care interventions
- Care coordination
  - Timely communication of test results
  - Timely exchange of clinical information to patients and other providers
  - Use of remote monitoring or telehealth

MIPS Clinical Practice Examples

- Beneficiary engagement
  - Establishment of care plans for individuals with complex care needs
  - Beneficiary self-management assessment and training
  - Using shared decision-making mechanisms
- Patient safety and practice assessment
  - Use of clinical or surgical checklists
  - Practice assessments related to maintaining certification
- PQRS, MU, & VBPM → merge → MIPS
- 2019 Medicare providers have 2 payment choices → MIPS or APMs
TOP 10 RISKS of PHYSICIAN COMPLIANCE

Identifying the Top 10 Risks: Complex Formula

- Regulation Analysis: PPACA, MACRA, and other exposures
- Docs in the News: OIG and DOJ Investigations
- Docs on the Internet: Physician Compare, Hospital Compare, CMS Billing Data, CG-CAHPS and more
- Docs in the Office: What physicians say keep them up at night
- Docs in Court: Changing compliance/malpractice exposures
- Doc Pay: PPACA quality reporting measures and impacts, 2016-2018
- Real-time experience
Top 10 Physician Compliance Risks

1. Electronic Health Care Records
2. Advanced Practice Providers
3. Clinical Practice Guidelines & Order Sets
4. Telehealth/Telemedicine
5. Social Media
6. Electronic Communications
7. Medical Apps
8. Disconnect: Compliance & Malpractice
9. Physician Burnout
10. Patient Portals

ELECTRONIC HEALTHCARE RECORDS (EHR/EMR)
EHR Liability Issues

- Cloning/Cut and Paste Notes
- Failing to record meaningful patient encounter data
- Using pre-populated templates, dropdowns, defaults, macros
- Upcoding → ROS
- Medication reconciliation inaccuracies
- Abnormal test results management
- Improper support staff management of results and data

EHR Liability Issues

- Inaccuracies and inconsistencies in typed and dictated notes
- Voice recognition issues
- Failure to check the “paper chart” or “scanned chart”
- Changing the note
- Failing to close and lock note before billing or releasing records
- Chart inconsistencies
- Failure to read office note created
- Future developments…
EHR Errors Can Hurt Patient Safety

- No firm data establishing EHR improves patient safety
- CRICO → evidence-based risk management group of companies owned by Harvard medical community
  - 248 medical malpractice cases w/serious unintended consequences from EHR use
    - 80% involved moderate to severe harm
    - Errors occurred in ambulatory > inpatient settings
    - Death more likely in inpatient settings
- Percentage of all IT-related malpractice cases:
  - Medication error (31%), Diagnostic error (28%), Treatment complications (31%), Other (10%)
  - 63% had user-related human factor issue v. 58% had system-related design or technology issue

Paper Days
If it’s not documented, you didn’t do it!
EHR Days
You documented it…did you do it?

OIG: Focused on EHR since 2014

- OIG EHR “Vulnerability Report”
- Objective:
  - Describe how CMS & its contractors implemented program integrity practices in light of EHR adoption
  - Concerned that EHRs may make it easier to commit fraud
- 2 Major areas where EHRs may be used to commit fraud:
  - Copy/Pasting
  - Over documentation

EHR Meaningful Use

• OIG Work Plan 2016:
  • OIG will perform audits to determine whether electronic health information is adequately protected – a security risk analysis of certified EHR technology is required
    • See 45 CFR § 164.308(a)(1) and 45 CFR § §170.314(d)(1)-(d)(9)
  • OIG will continue review of EHR incentive payments for meaningful use, through 2016 ($20B was paid through July 2015)
  • Providers who did not meet Meaningful Use requirements saw PFS payment reductions beginning 2015
  • CMS issued hardship exceptions information for 2017+

EMR System Security and PHI Breach: Sources of Breach

HHS Office for Civil Rights (2010)
Interoperability by 2018: SGR Repeal and Medical Provider Payment Modernization Act of 2015 (HR 1470)

Declares it a national objective to achieve widespread exchange of health information through interoperable certified electronic health records technology nationwide by December 31, 2018


Interoperability by 2024: ONC Ten Year Roadmap

• 2014: Office of the National Coordinator of Health Information Technology (ONC) issues a “Ten Year Roadmap to Interoperability.”

• By 2024, all healthcare providers, health systems, and the public should enjoy interoperative interfaces between all providers, and all EMR systems.

Advanced Practice Providers

- Number & Use of APPs Increasing Nationally
  - Nurse Practitioner (CRNP)
  - Physician Assistant (PA)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Nurse Midwives (CNM)
  - Advanced Practice Nurses (APNs)

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Expanding APP Duties

• Competent to diagnose & treat at an advanced level
• Delegation and team effort allows physician/APP to deliver higher quality of care
• Physician may attend to more serious patient health care concerns
• APPs deliver less expensive treatment
• APPs improve access in underserved areas
• Promoted as a solution to the national physician shortage

Walsh JH. Gastroenterology 2000;188:459-60.

Expanding APP Duties

• Discussion nationally regarding the roles APPs should play in medical care (Physician shortage, increasing numbers of insureds)
• APPs taking on duties once solely performed by physicians
  • Independent Mini Clinics (Pharmacies)
  • VHA proposal to allow NPs to practice throughout the system without physician supervision
• State Scope-of-Practice Rules differ widely on autonomy
• Rapid changes in state laws and regulations
Regulatory Pressures to Expand APP Duties

- Increasing Patient Volumes under PPACA
- Physician Burnout and Workload
- Financial Necessity/Extender Productivity
- Financial Necessity/Cost Savings
- Institutions using APPs as:
  - Hospitalists
  - Medically Underserved Areas
  - Emergency Departments and high-volume triage roles

APP Independent Practice vs. Supervised Practice

- Some states allow independent practice with approval of State Boards
- Some states require supervised practice
  - Collaborative Practice Agreement with Supervising Physician(s)
- In supervised practice, physicians are typically responsible for actions of the APP. Physicians bear vicarious liability for actions of any "agent"
  - Lack of supervision
  - Untimely referral to consultant
  - Failure to diagnose
  - Inadequate examination
Nurse Practitioner Supervision Environment

Updated 5/12/2015


CLINICAL PRACTICE GUIDELINES & ORDER SETS

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Clinical Practice Guidelines (CPGs)

• National Institutes of Medicine (IOM)
• CPGs Defined:
  “Systematically developed statements to assist the practitioner with patient decisions about appropriate health care for specific clinical circumstances.”

Clinical Practice Guideline
Purpose and Development

• Purpose of CPGs
  • Improve effectiveness & efficiency of medical practice
  • Standardize practice
  • Improve healthcare outcomes
• CPGs developed by professional societies, healthcare organizations, government, international organizations
CPG Growth 1974-2011: Number of English Language References
NIH Database, PubMed

![Graph showing CPG Growth from 1974 to 2011.](image)

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CPG Example: Incidental Renal Mass on CT Scan

![Flowchart for Incidental Renal Mass on CT Scan.](image)

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CPG Example: Quality Indicators for Colonoscopy

1. Appropriate indication
2. Informed consent is obtained, including specific discussion of risks associated with colonoscopy
3. Use of recommended post polypectomy and post cancer resection surveillance intervals
4. Use of recommended ulcerative colitis/Crohn's disease surveillance intervals
5. Documentation in the procedure note of the quality of the preparation
6. Cecal intubation rates (visualization of the cecum by notation of landmarks and photo documentation of landmarks should be present in every procedure)
7. Detection of adenomas in asymptomatic individuals (screening)
8. Withdrawal time: mean withdrawal time should be >6 minutes in colonoscopies with normal results performed in patients with intact anatomy
9. Biopsy specimens obtained in patients with chronic diarrhea
10. Number and distribution of biopsy samples in ulcerative colitis and Crohn's colitis surveillance.
11. Mucosally based pedunculated polyps and sessile polyps < 2 cm in size should be endoscopically resected or documentation of unresectability obtained
12. Incidence of perforation by procedure type (all indications vs screening) is measured
13. Incidence of post polypectomy bleeding is measured
14. Post polypectomy bleeding managed non-operatively


Colonoscopy Guidelines
real time...
Patient Name: [Redacted]
Address: [Redacted]
Age: [Redacted]
Gender: [Redacted]
Procedure: Colonoscopy
Date of Birth: [Redacted]
Address: [Redacted]
Date: 3/20/2015
Provider: [Redacted]
Admit Type: Inpatient
Allergy ML: [Redacted]
Admit Date: 3/16/2015
Procedure Date: 3/16/2015
Complaints: No significant complaints.
Indications: Screening for colorectal malignancy.
Medications: None.

Procedure: The examination was performed as follows:
- The patient was placed in the left lateral decubitus position.
- The colon was prepared with a cleansing enema.
- Once the colon was clear, the examination was continued.
- No significant findings were noted.
- The procedure was completed without any complications.

Findings:
- The colon was normal.
- No polyps or masses were noted.

Impression:
- Normal colon.

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CPG Risk Education Resources

- General Professional Organizations
  - American College of Physicians
  - American College of Surgeons
- Specialty Organizations Examples
  - www.gi.org (American College of Gastroenterology)
  - www.gastro.org (American Gastroenterological Association)
  - www.aasld.org (American Association for the Study of Liver Disease)
- U.S. Department of Health and Human Services
  - www.guidelines.gov

TELEMEDICINE
Telehealth v. Telemedicine

- **Telehealth** → overall access to health information rather than the provision of direct patient care
- **Telemedicine** → subset within Telehealth attributed specifically to patient care
- Specific definitions vary by state and organization

Telehealth Sites

- **Distant site** → site(s) at which physician or other licensed practitioner delivering service is located
- **Originating site** → location of patient at time service is being furnished
  - Occurs via telecommunications system
- **Originating sites authorized by law:**
  - Physician offices, critical access hospitals, rural health clinics, federally qualified health centers, hospital-based renal dialysis centers, skilled nursing facilities, community health centers
CMS Payment for Telehealth

- CMS Telehealth site:
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

- Medicare Learning Network Resources:

- Submit claims for telehealth services
  - CPT or HCPCS code for professional service along with telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT).
  - Provider certifies beneficiary was present at an eligible originating site for telehealth service.

CMS Payment for Telehealth (partial listing)

- Emergency Department Visits
- F/U consults to inpatient hospital or SNF beneficiaries
- Subsequent hospital services (1 visit every 3 days limit)
- Kidney disease education services
- Diabetes self management training services
- Behavioral assessment and intervention
- Psychotherapy
- Pharmacologic management
- ESRD services
- Annual Wellness Visit, Personalized Prevention Plan of Service (PPPS)
Telemedicine: State Regulatory Barriers Analysis

- Open: 22
- Limited: 26
- Closed: 2


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Telemedicine: Stringent Rules for Physician-Patient Encounter

- Open: 22
- Stringent: 28
  - Plus DC


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Parity Laws: Private Insurance Telemedicine Coverage

Open: 22  
Limited: 26  
Closed: 2  

Telehealth Potential Risks

- Compliance with State Regulation regarding first face to face encounter, in state license, out of state cross border licensing requirements – these vary widely, state to state. Research state medical boards and legal code.
- Related concerns about location of patient during telehealth visit. Does out of state communication violate state regulation?
- Patient education on quality limitations of telemedicine visits.
- Telehealth Informed Consent, including impact of quality of transmission on diagnosis; alerting patient that information transmitted may not be secure.
- Referral network availability for patients requiring follow up services.
- Compliance with CMS as well as State regulations.
- PPACA and MACRA expectations regarding the growth and use of telehealth.
SOCIAL MEDIA

Social Media: Laws & Regulations

- Federal legislation
- Medical malpractice
- Professional ethics
- Employment issues
Social Media: Laws & Regulations

HIPAA

- **Federal Legislation:** HIPAA
  - Most apparent issue regarding social media in health care
  - Standardized electronic processing of PHI
  - Do not disclose: Name, geographic subdivisions smaller than a state, date of birth, date of death, social security number, telephone number, e-mail address

- **University Medical Center Case**
  - Governor Barbour of Mississippi tweets about Legislature recognizing fiscal situation
  - Employee Carter tweets Governor should schedule his routine appointments during the week when UMC is open instead of paying overtime to 15-20 staff on a weekend
  - **ISSUE:** PHI breach v. exercise of right to free speech
  - **OUTCOME:** Employee Carter resigns

Medical Malpractice

- Use of social media by health care professionals affects course of litigation
- Generally, relevant social media communications & other electronic stored data must be produced
- Surgeon uses social media (Twitter) for patient education updates
  - Plaintiff uses Tweets as "statement against interest" → hearsay comes in as evidence
  - Educational video used as evidence surgeon did not meet the standard of care
Social Media: Laws & Regulations

Professional Ethics

- Employed physicians of health care organizations
  - Need to comply with laws and ethics rules of those organizations
  - Subject to additional levels of discipline internally
- Most state Medical Boards found violations of online professionalism
  - Inappropriate contact with patients
  - Inappropriate prescribing
  - Misrepresentation of credentials
  - Misrepresentation of clinical outcomes


Social Media: Laws & Regulations

The House Staff

- Medical student & young physician perspective on social media
  - Medical students are heavier users of social media than older physicians
  - Employed by health system/teaching institution → internal rules & risks
- Challenge: Requisite level of professionalism
  - 2009: 60% U.S. medical schools reported medical students posting inappropriate unprofessional content online


Bottles K, Kim J. PEJ 2013:September-October 96-98.
Social Media: Laws & Regulations
Attending Physicians → The Real Deal

- Sexting during surgery
- Arthur Zilberstein, MD (Swedish Medical Center – Seattle, WA)
- Allegations:
  - During surgeries sent explicit “selfies,” texted sexual messages, arranged meetings on hospital property during work hours for sex,…
  - C-sections, pediatric appendectomies, epidurals, cardiac procedures, tubal ligations
- License suspended indefinitely (February 2015)

Patients and Social Media
Patients and Social Media

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ELECTRONIC COMMUNICATIONS

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Dismissed Patient Calls to Physician’s Personal Phone

- Patient receives Dismissal Letter after offering female physician a Rolex watch as a gift, and making verbal advances during an office visit.
- Messages from physician to compliance officer after patient receives letter:
  - **Message 1:** He called back 50 min later and left a very verbose message - he received the dismissal letter and is asking to "reconcile" - he states he doesn't understand why I am mad at him, goes on and on like emails. I'll update if I get further messages.
  - **Message 2:** He called a total of 4 times. Last call at 2 AM Christmas morning but no more. Documented in EMR. I didn't contact police since calls didn't continue.

Patient Sends Photo of Genital Anatomy to Physician e-mail

- Physician contacts compliance officer after receiving graphic photo from patient, and offers this explanation:
  - He emailed that photo overnight and called, and we spoke this morning. He verbally threatened that if he contacted a lawyer that there would be issues, especially with the insurance. He might be referring to my coding of his revision surgeries to try to get coverage for him so that he didn't need to be self pay.
  - I did explain on the phone that I do not know why he continues to heal asymmetrically, and that the asymmetry is worse when he is relaxed in the shower (evidenced by his photo). I can only assess him in the office and based upon the photos from October 2015, although not perfect, it seemed acceptable. He is upset by how much he paid back in 2014, what he had to pay with the revisions due to his insurance and the way things look now.
Mobile Devices & Applications

- “As mobile devices and applications have become more user friendly, affordable, and powerful, the appeal to...healthcare providers has grown exponentially.”
  - Tim Herbert, VP research of CompTIA (2011 Press Release)
- > 50% Physicians with smart phones use mobile medical apps on daily basis
Medical Mobile APPs v. “Medical Mobile APPs”

= ???

Medical Mobile APPs

- Mobile Medical Apps
  - Medical Apps v. “Medical Apps”
  - Increasingly used by patients & providers
  - Potentially create more than Product Liability Issues
  - Examples:
    - Monitoring & controlling → insulin pump delivery
    - Stethoscope function
    - Patient analysis → Radiation dose, BMI, vital signs
    - Reference apps → drug interaction, drug allergy
    - Communication → access health records & other data

http://searchhealthit.techtarget.com/healthtechchanges/meaningfulhealthcarereformblog/the-different-types-of-mobile-healthcare-apps

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I. Introduction

The Food and Drug Administration (FDA) recognizes the extensive variety of actual and potential functions of mobile apps, the rapid pace of innovation in mobile apps, and the potential benefits and risks to public health represented by these apps. The FDA is issuing this guidance document to inform manufacturers, distributors, and other entities about how the FDA intends to apply its regulatory authorities to select software applications intended for use on mobile platforms (mobile applications or “mobile apps”). Given the rapid expansion and broad applicability of mobile apps, the FDA is issuing this guidance document to clarify the subset of mobile apps to which the FDA intends to apply its authority.

Many mobile apps are not medical devices (meaning such mobile apps do not meet the definition of a device under section 201(h) of the Federal Food, Drug, and Cosmetic Act (FD&C Act)), and FDA does not regulate them. Some mobile apps may meet the definition of a medical device but because they pose a lower risk to the public, FDA intends to exercise enforcement discretion over these devices (meaning it will not enforce requirements under the FD&C Act). The majority of mobile apps on the market at this time fit into these two categories.

Consistent with the FDA’s existing oversight approach that considers functionality rather than platform, the FDA intends to apply its regulatory oversight to only those mobile apps that are medical devices and whose functionality could pose a risk to a patient’s safety if the mobile app were to not function as intended. This subset of mobile apps the FDA refers to as mobile medical apps.

FDA is issuing this guidance to provide clarity and predictability for manufacturers of mobile medical apps. This document has been updated to be consistent with the guidance document entitled “Medical Device Data Systems, Medical Image Storage Devices, and Medical Image Communications Devices” issued on February 9, 2015.
Mobile Medical APPs: Potential Risks

- Technology quality
  - Interference with accuracy of diagnosis
  - Interference with accuracy of treatment
- Guidelines
  - Some exist → another developing issue
  - NB: Standard of care issue
- Hacking
- Quality measurement?
- Certification requirements?
- Training requirements?
Compliance and Malpractice

- Government Accountability Office (GAO)
  - “…beneficiaries…who receive healthcare from providers who adhere to PPACA…may receive higher quality of care…Conversely, those who receive care from providers who fail to do so may receive lower quality of care.”
  - “…it is possible that, if these (PPACA) standards and guidelines become accepted medical practice, they could impact the standard of care against which provider conduct is assessed in medical malpractice litigation.”

www.gao.gov/assets/590/589657.pdf

Compliance/Malpractice Case Study: Mark Midei, MD

- 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.
Compliance/Malpractice Case Study: Mark Midei, MD

- 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 he/she received a stent that was not medically necessary. DHHS joins suit.
- 6/09: OIG begins a civil 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.

Compliance/Malpractice Case Study: Mark Midei, MD

- 10/09 to 2/10: Letters are sent advising patients to consult with their Cardiologist because of unnecessary stents. Extensive advertising by the plaintiff’s bar ensues, including Super Bowl ads.
- 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 on the basis of four medical records.
Compliance/Malpractice Case Study: Mark Midei, MD

- 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 (CHI).
- 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.
- Final Analysis:
  - Over 600 medical malpractice claims filed against Dr. Midei
  - Additional claims filed against many of his practice partners
  - An estimated $150M spent by health system to settle 550+ malpractice claims
  - Remaining 40 unsettled claims will be tried from 2016-2020, unless settled prior to trial

51 Hospitals Pay $23M to Resolve False Claims Act Allegations Related to Implantable Cardiac Devices

- DOJ investigation into cardiac device implantation has yielded > $280M (with current agreements) to date
  - More than 500 hospitals have settled to date (2003-2010)
- February 17, 2016 DOJ Press Release
  - U.S. ex rel. Ford et al. v. Abbott Northwestern et al. No. 08-cv-20071 (S.D. Fla.)
  - DOJ “reached settlements with 51 hospitals in 15 states for more than $23 million related to cardiac devices that were implanted…”
    - Implantable Cardioverter Defibrillator (ICD)
51 Hospitals Pay $23M to Resolve False Claims Act Allegations Related to Implantable Cardiac Devices

- National Coverage Determination (NCD) provides that ICDs should not be implanted in patients who suffered MI or recently had cardiac bypass surgery or angioplasty/stent for 40 days & 90 days, respectively
- Theory is that heart may improve to point that ICD is not necessary
- NCD expressly prohibits ICD implantation during these waiting periods with certain exceptions

Smile! You’re on Physician Compare

- 900,000 physicians listed
- 140,000 hits/day
- CMS must allow physicians & other professionals to have reasonable opportunity to review their results through PECOS before posting
  - 30 day annual preview period for all measurement data occurred October, 2014
CMS Releases Provider Billing Data

  - Dr. Gregory Sampognaro is one of the busiest interventional cardiologists in the United States. Dr. Sampognaro ranked 17th in the U.S. in 2012 in the number of diagnostic angiograms and angioplasties performed.
  - Interview with Dr. Sampognaro: “I already know that I’m one of the busiest cardiologists in the country. The reason is geography. I practice in an extremely underserved area. There are only four interventional cardiologists…I’m one of four.”
  - Where does Dr. Sampognaro work?

The Value Based Modifier (VM):
Publicly Available Quality Data

- Quality data reported under PQRS equals modification to payments under the Physician Fee Schedule (PFS)
- VM use began 2015 for groups of 100 or more; full implementation 2017
- Physician groups of 10 or more must report beginning 2016; expect all physicians to report by 2017
- Quality tier system and PFS reductions of up to 2%
- QRUR (Quality and Resource Use Reports) are issued each fall, and indicate how the value based modifier will impact individual physician reimbursement
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
Are you reviewing PQRS and QRUR Reports?

• 2016 PQRS Reports

• 2016 QRUR Reports (2015 data)
  • https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QURUR.html

• To Request a CMS QualityNet Informal Review of Incorrect VM Assessment
  • https://www.qualitynet.org/portal/server.pt/community/pqri_home/212

PHYSICIAN BURNOUT
Physician Burnout

• Physician burnout → significant area of concern and investigation for decades
• Definitions:
  • Syndrome characterized by a loss of enthusiasm for work (emotional exhaustion),
    feeling of cynicism (depersonalization), and a low sense of personal accomplishment
  • Emotional condition marked by tiredness, loss of interest, or frustration that
    interferes with job performance → usually regarded as the result of prolonged stress
• Research shows that physician burnout can be connected with increased rates of
  medical errors, riskier prescribing patterns, and lower patient adherence to chronic
  disease management plans
• Burnout has been shown to negatively effect patient care

www.aafp.org/about/policies/all/physician-burnout.html
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The Physicians Foundation

• National not-for-profit grant making organization dedicated to advancing the
  work of practicing physicians and to improving the quality of healthcare for all
  Americans
• Founded in 2003 through settlement of a class action law suit brought by
  physicians and state medical associations against third-party payers
• Board of Directors: physicians and medical society leaders across the United
  States

www.physiciansfoundation.org
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Physicians Speak Out: The Physicians Foundation

• 2014 Biennial Survey
  • Every other year a national survey of physicians is conducted
  • Provides a “state of the union of the medical profession”
  • Surveys sent to over 650,000 physicians
    • 80% of all physicians currently involved in patient care
  • 20,000+ physicians responded in all 50 states
  • Data derived from responses to > 35 questions
  • Over 13,000 written comments by physicians on current state of medical profession & healthcare system


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Physicians Speak Out: The Physicians Foundation

• 81% physicians overextended or at full capacity
• 44% physicians plan to reduce patient access to services
• 35% physicians independent practice owners
• 69% physicians believe their clinical autonomy is limited & their decisions compromised
• 26% physicians participate in an ACO
  • 13% of this group believe ACOs will enhance quality & decrease costs
• Physicians spend 20% of their time on non-clinical paperwork


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Physicians Speak Out: The Physicians Foundation

…and about PPACA

• 46% Physicians give PPACA grade of D or F
• 25% Physicians give PPACA grade A or B
• 39% Physicians accelerating retirement plans due to PPACA

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2015 Physician Burn Out By Specialty

Burnout and Happiness in Physicians: 2013 v. 2015

Medscape Physician Lifestyle Report: 46% of all physicians responded that they had burnout, which is a substantial increase since the Medscape 2013 Lifestyle Report, in which burnout was reported in slightly under 40% of respondents.
Patient Portals

- Secure online website that gives patients convenient 24 hour access to provider communication and personal health information from anywhere with an Internet connection
- Secure username and password required
- Theory is that this will improve patient outcomes

https://www.healthit.gov/providers-professionals/faqs/what-patient-portal

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Patient Portals

- Simple Patient Portals allow viewing of:
  - Recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results, et cetera
- More Advanced Patient Portals allow:
  - Exchange of secure e-mail with the health care team, request prescription refills, schedule non-urgent appointments, check benefits and coverage, update contact information, make payments, download and complete forms, view educational material

https://www.healthit.gov/providers-professionals/faqs/what-patient-portal
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Patient Portals

- Required by HITECH
- Part of Meaningful Use 3
- Developing area of liability
- Areas of risk:
  - HIPAA data breach
  - Inappropriate use
  - Inappropriate content
  - Other evolving areas of potential risk exposure
  - Examples…

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Patient Portal Misuse

EDUCATIONAL APPROACH to the PROBLEMS
Reaching, Engaging & Educating Physicians

- Understand your physicians
- Focus on what you exactly want to teach or change
- Define your educational goal(s)
- Consider using the Mindfulness Model → EHR & communication
- Keep a calm demeanor

About Physicians in General

- Main Goal: Deliver quality care in effective & safe manner
- Competitive, OCD, delayed gratification & clinical
- Tend to be detailed overachievers and/or survivors
- Think in terms of medical malpractice avoidance
- No prior training about fraud, abuse, & medical malpractice
Mindfulness

- Emotional reactions can hijack the ability to think clearly and act skillfully
- Mindfulness can be used as a learning tool for changing habitual emotional reactions
- Better effect the more it is practiced
- Negative emotions that tend to dominate awareness
  - Irritation, impatience, anxiety, anger, fear, et cetera

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States of Mind

Reasonable Mind is:
- Cool
- Rational
- Task Focused

Wise Mind is:
- Wisdom with each person
- Sees value of both reason & emotion
- Brings left & right brains together

Emotion Mind is:
- Hot
- Mood Dependent
- Emotion Focused

Identifies middle path

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Mindfulness in Daily Practice & Teaching

◇ 4 STEP MODEL:
◇ 1. STOP
◇ 2. BREATHE
◇ 3. REFLECT
◇ 4. CHOOSE

SUMMARY & CONCLUSIONS
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Thank You
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