Eastern Association for the Surgery of Trauma

EAST Leadership Development Workshop Part III
A Formula for Success as a Leader in Trauma

January 13, 2015
Disney's Contemporary Resort
Lake Buena Vista, Florida

Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the Eastern Association for the Surgery of Trauma (EAST). The American College of Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™
The American College of Surgeons designates this live activity for a maximum of 7.5 *AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**This workshop qualifies for Self-Assessment Credit.

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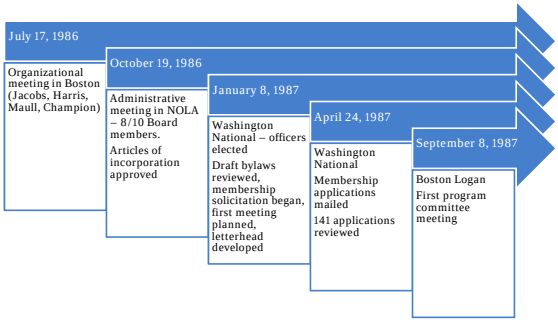
American College of Surgeons
Division of Education

EAST – Where we have been, and where we are going.....

Kimberly A. Davis, MD, MBA, FACS, FCCM
Professor of Surgery
Chief of the Section of Trauma, Surgical Critical Care and Surgical Emergencies
Yale School of Medicine

Yale SCHOOL OF MEDICINE

The infancy



Yale SCHOOL OF MEDICINE SLIDE 1

1988 – The first meeting 99 members and 43 guests

- EAST Executive Board
- Kimball Maull – President
- Burt Harris – Pres Elect
- Howard Champion – Sec/Tres
- Len Jacobs – Recorder
- Ray Alexander – Local Arrangements
- Andrew Burgess
- Thomas Gennarelli
- Norm McSwain
- Mike Rhodes
- Bill Schwab

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1st Scientific Assembly for the Eastern Association for the Surgery of Trauma

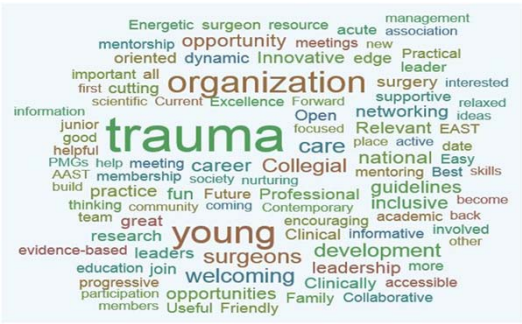
Longboat Key, Florida
January 13-16, 1988

Session I	January 14	7:50 am – 12:00 Noon
Session II	January 14	2:00 pm – 5:00 pm
Session III	January 15	8:00 am – 12:00 Noon
Session IV	January 16	8:00 am – 12:00 Noon

Yale SCHOOL OF MEDICINE SLIDE 2

The original executive committee

What the EAST brand means.....

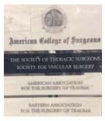


EAST mentors

My presidents

Restructuring of the central office

- September 2007 – BOD meeting
  - Las Vegas NV at the AAST
- Decision to move the offices to the ACS building with a new management agreement
- Christine Eme hired Dec 2007
  - Katie Dwyer 2012
  - Rachel Dixon 2013
  - Kelly Leiseca 2014



Fellow recruitment

- Started in 2009
  - Truncated application process
  - Decreased application fee
- Total recruitment – 174 to date
  - 170 still active members (98%)
  - 38 fellows in training in process for 2015

Join EAST

Become A Member of EAST!

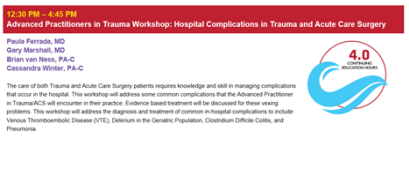
Fellow-In-Training

Meet the requirements for Active or Provisional but are currently completing a Trauma/Surgical Critical Care/Acute Care Surgery Fellowship. Fellowship cannot be completed prior to June 30th the year following date of application. - Application deadline November 30th.

$75 First Year/ Dues amount for Subsequent Years Depending on Membership Status (e.g. Active or Provisional)

Advanced Practitioners

- Ad hoc committee formed in 2009
- Specific programming started in 2011
- MOU with STN signed in 2013
- First APP programming by EAST at the 2014 STN meeting




Patrick M. Reilly
MD, FACS
2009


Donald H. Jenkins
MD, FACS
2010

Pediatric trauma

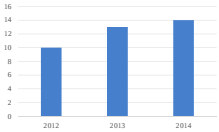
- Ad hoc committee
- The pediatric trauma society formed in 2011
  - First annual meeting 2014
- Major contributions to online education


Donald H. Jenkins
MD, FACS
2010

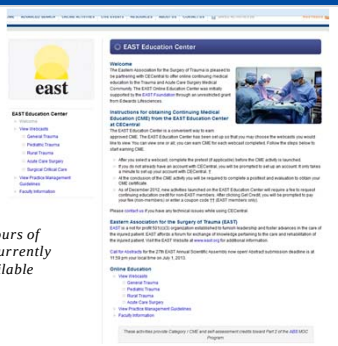
Mentoring Program

- Started in 2012
- Research ad hoc committee
  - Chair Vicente Gracias
- Two year program
- Mentor/mentee pairs
- On-line application process


Erik S. Barquist
MD, FACS
2011



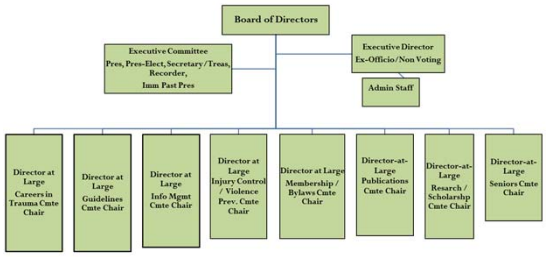
On-line education - 2012



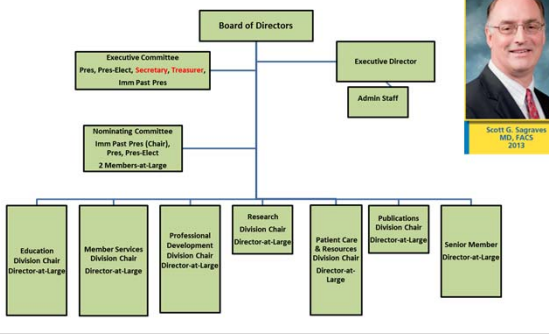
Jeffrey P. Salomone
MD, FACS, NREMT-P
2012

27 hours of CME currently available

Current board structure



Proposed board structure



Scott G. Sagraves
MD, FACS
2013

Benefits of "new" structure

- Meets the legal changes since inception
- Keeps the opportunities to volunteer in place
- Provides clear lineage to ascend to the Presidency
- Emphasizes work effort, not politics
- Provides clear structure to the Board and improves the Board's ability to efficiently govern
- Details responsibilities of Chairs
- Maintains relevance to the Members of EAST

1988 –99 members and 43 guests

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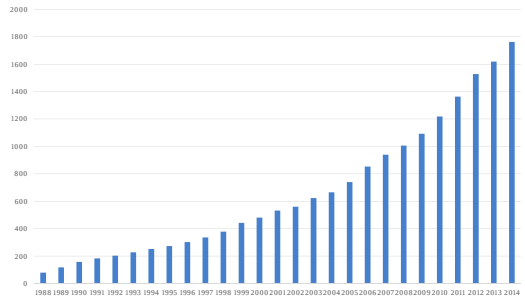
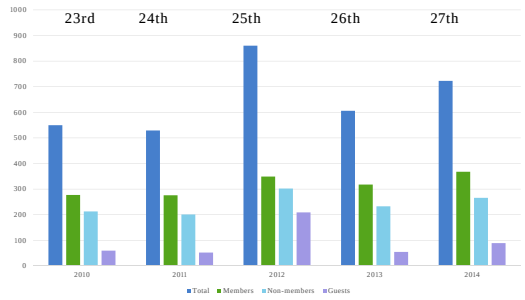
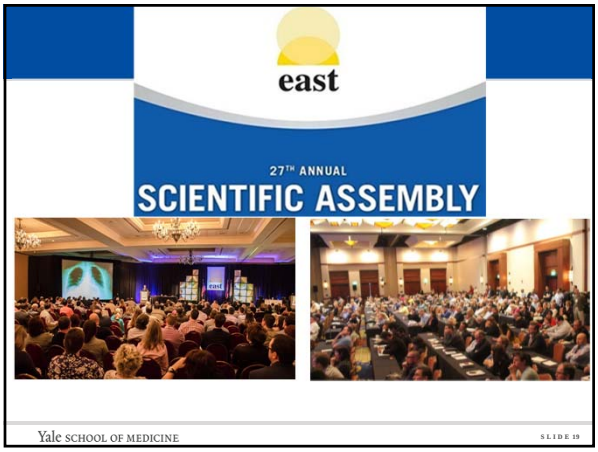
EAST Membership



Meeting attendance



Yale SCHOOL OF MEDICINE SLIDE 18

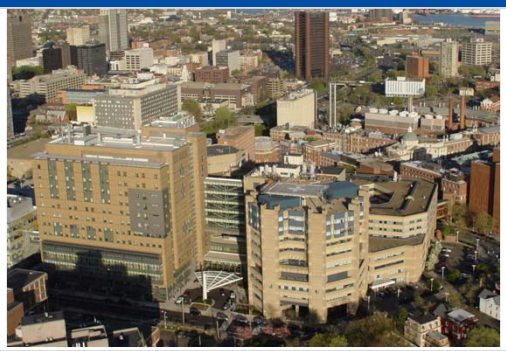


Yale SCHOOL OF MEDICINE SLIDE 19

Where will we go from here?

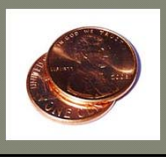
Yale SCHOOL OF MEDICINE SLIDE 20

Questions?



Mentoring: How to Optimize Both Sides of the Coin

Kimberly Nagy, MD
Cook County Trauma Unit



Mentoring is a brain to pick, an ear to listen, and a push in the right direction.
- John Crosby

What is a Mentor?

An experienced and trusted advisor
-Oxford dictionary

An individual, usually older, always more experienced, who helps and guides another individual's development, ~~not for personal gain~~
- about.com

A mentor is…

- A senior member in a field who guides a trainee
  - personal
  - professional
  - educational matters
- Someone who helps
  - guide
  - advise
  - find opportunities

Mentoring Models

- Defined – one mentor/one mentee
  vs.
- Diffuse – several mentors per mentee

- Formal
  vs.
- Informal

Formal mentoring

- Dyad Model – Traditional/defined
  - Distance
  - Functional
  - Speed
- Peer Model
  - Facilitated
- Group Mentoring

Informal mentoring

- Residents and Students on service
- Common interest, project, etc.
- Advise on fellowships & jobs
  - LOR
  - Phone calls
- Get them involved in societies, committees, presenting

Research mentoring

- Specialized relationship
  - Guide hypothesis
  - Advise on IRB/grant applications
  - Review & edit manuscript
  - Assist with stats
  - Remind deadlines
- May act as Sub-Investigator
- Move from 1st to last autho

Advantages of mentor programs

- A way to improve the field, one mentee at a time
- Influence on career choice
- Success in research

Examples of Programs

- EAST –
  - overseen by committee
  - Preliminary conference call
  - Periodic checks
- Rush University –
  - Previously resident driven
  - Now formalized with required meetings
- Mission Statement or Contract

What does a mentee want?

- Access to networking
- Help with clinical skills/problem solving
- CV development
- Establish career goals and guide toward
- Confidence building
- Role modeling
- Feedback/coaching

Characteristics of a good mentee

- Open to feedback
- Active listener
- Respectful of mentor's time and input
- Responsible to time lines
- Motivated

Expectations of a good mentee

- Come to meetings prepared with topics or concerns to discuss
- Take responsibility to "drive relationship"

What does a mentor do?

- Provide career guidance
- Advocate for mentee
- Provide emotional support
- Help with work/life balance
- Warn mentee of potential pitfalls

Who can be a mentor?

- Anyone willing to spend time with students, residents or junior faculty
- Junior faculty can mentor – recent experience
- Little formal training available

Characteristics of a good mentor

- Professional role model
- Devotes time/energy to relationship
- Provides feedback

- Should be:
  - Altruistic, honest, trustworthy, respectful
  - Active listener
  - An empowering, inspiring, liberating partner

Expectations of a good mentor

- Ensure that mentee reaches milestones
- Introduce into academic environment
- Help establish professional relationships
- Provide support and challenges
- Advise on opportunities

Establish a relationship

- This is a 2-way relationship
- Mentor should get to know mentee
  - Determine goals, career plans
  - Identify percieved strengths and weaknesses
- Establish:
  - What they want to learn
  - Specific interests or activities
  - Set time line

Continue the relationship

- Regular meetings vs. prn
  (q week, month, quarter, etc)
- Review progress - checklist
- Learn new concerns
- Advise of new opportunities

- Avoid cheerleading
- Thoughtful feedback – complement or critique

Pitfalls of mentoring

- Time constraints
- Personality differences
- Poor communication
- Inexperienced mentor
- Lack of commitment
- Inappropriate praise or criticism

What about a bad relationship?

- Competition
- Conflicts of interest
- Unethical or immoral behavior
- Exploitation, secrecy or dishonesty

After the relationship

- Sometimes best to acknowledge the failure and move on
- Determine what went wrong for future relationships
- Most end naturally with career transition
- Different mentors at different stages

Benefits to the mentee

- Develop communication skills
- Groom future allies – job opportunities
- Gain skills and understanding
- Increased motivation
- Point of stability
- Independent voice
- Receive guidance in unfamiliar area

More benefits

- Individual encouragement & recognition
- Improved self-esteem
- Confidence to challenge oneself
- Experience with networking
- Access to support system
- Foundation of professional network

Rewards to the mentor

- Develop communication skills
- Build leadership and management skills
- Groom future allies, junior partners
- Ongoing attention to own career develop
- Learn from mentee – skills, understanding
- Pride as mentee excels
- Create a legacy

Long term benefits of mentoring

- Employees with mentors earn more
- Promoted earlier
- More likely to publish
- Greater career satisfaction
- Most successful faculty have benefitted from the counsel of one or more mentors

In summary:

- Mentor is the "little voice"
- Mentoring is a way to "Pay it Forward"
- Consider mentoring if you enjoy helping others and watching them achieve goals

In learning, you will teach and in teaching you will learn. -Phil Collins

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Coding and Billing for Trauma and Surgical Critical Care

Samir M. Fakhry MD FACS

Charles F. Crews Professor and Chief, General Surgery, Dept. of Surgery
Physician Leader, Surgical Acute and Critical Care Service Line
Medical University of South Carolina, Charleston, SC

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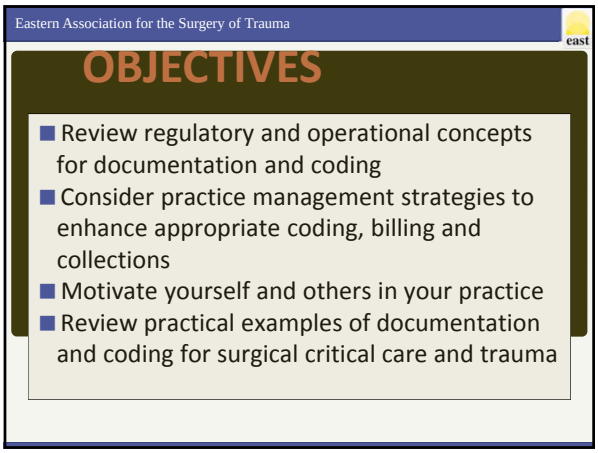
DISCLOSURES

- Nothing to disclose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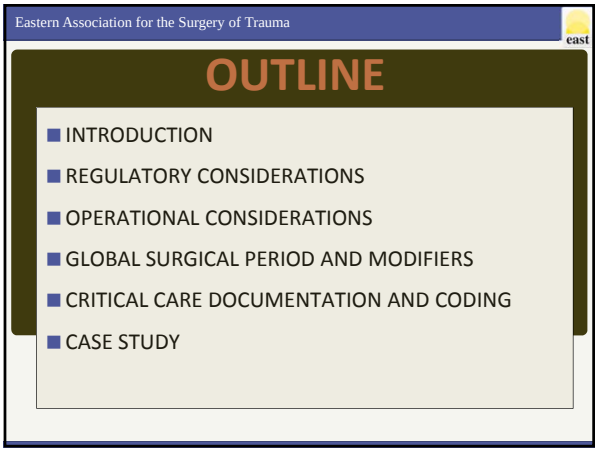
OBJECTIVES
Review regulatory and operational concepts for documentation and coding
Consider practice management strategies to enhance appropriate coding, billing and collections
Motivate yourself and others in your practice
Review practical examples of documentation and coding for surgical critical care and trauma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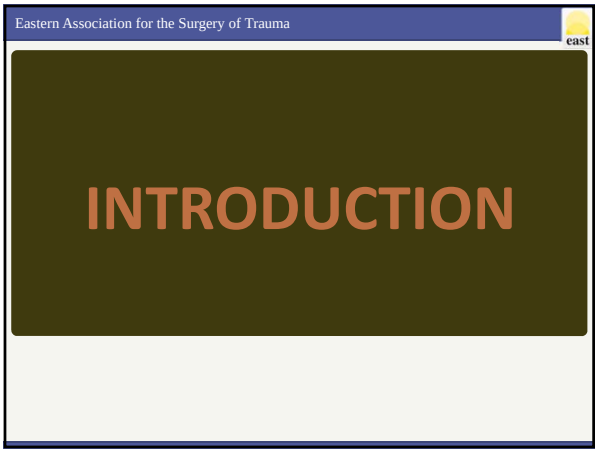
OUTLINE
INTRODUCTION
REGULATORY CONSIDERATIONS
OPERATIONAL CONSIDERATIONS
GLOBAL SURGICAL PERIOD AND MODIFIERS
CRITICAL CARE DOCUMENTATION AND CODING
CASE STUDY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INTRODUCTION

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CODING

- Codes describe physician services and medical diagnoses:
  - Common Procedural Technology (CPT) codes: describe operations
  - Evaluation and Management (E&M) codes: describe physicians non-procedural activities (so-called "cognitive" services)
  - ICD-9 codes (soon to become ICD-10 codes): describe medical diagnoses
- Coding refers to the process of selecting:
  (1) a numeric descriptor of the professional service provided AND
  (2) the medical diagnosis prompting the physician to provide that service
- Diagnostic codes are then "matched-up" with E&M codes or CPT codes

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BILLING, CODING AND DOCUMENTATION

- Billing for professional services cannot be accomplished without coding
- Coding must be accurate and supported by documentation in the clinical record
- Documentation must be complete and legible
- Some payors will seek to deny payment and assume you are overbilling (under-documenting?)
  - Disclaimer: *CMS (HCFA) documentation guidelines were in flux at one point; guidelines now in force are from 1995. New variations appear constantly. It is imperative that you maintain excellent, regular communication with your coding and billing group*

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HOW WE'D LIKE IT TO WORK (or Medicine in the good old days)

- We go to school and learn surgery
- We get a job
- We work really hard
- We get paid really well
- There is no silly paperwork
- All the patients say thank you

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HOW IT REALLY WORKS

We work really hard, then we work really hard to get paid

- Billing for professional services cannot be accomplished without coding → To get paid, you have to send a bill describing what you did
- Coding must be accurate and supported by documentation in the clinical record → What you write in the chart is what you did
- Documentation must be complete and legible → If I can't read it, you didn't do it
- Some 3rd-party payors maydeny payment and assume you are overbilling (under-documenting?) → You are committing fraud

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REGULATORY CONSIDERATIONS

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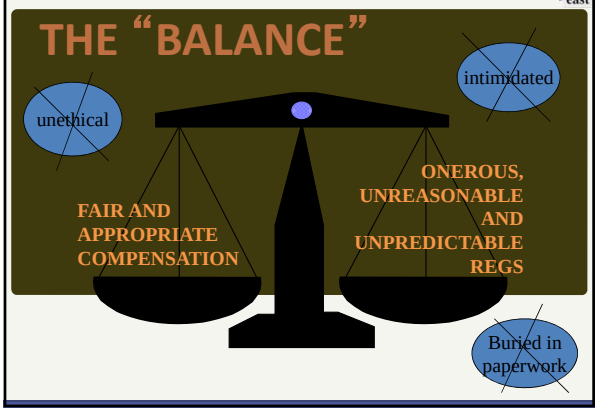
THE "BALANCE"



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LEGISTLATIVE UPDATE

- In November 2003, Congress approved the Medicare Prescription Drug, Modernization and Improvement Act of 2003 by a vote of 220 to 215 in the House and 54 to 44 in the Senate
- President Bush signed bill into law 12/8/03
- Among its (many) provisions, the bill prohibits the implementation of new E&M guidelines until HHS conducts pilot projects and consultation with a range of practicing physicians

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Health care fraud still a key target of federal False Claims Act

Physicians are seldom named in false claims cases but are often in a position to blow the whistle on fraud they observe.

AMY LYNN SORREL
AMNEWS STAFF

Health care continues to top the government's list of federal fraud investigation priorities, yielding the lion's share of recoveries in false claims cases in 2008.

The latest figures from the Dept. of Justice show enforcement officials recouped $1.34 billion in settlements and judgments under the False Claims Act in the fiscal year ending Sept. 30. Of that total, $1.12 billion, or 84%, came from health care entities. The act gives federal officials authority to prosecute fraudulent billing of any government program.

That number represents a drop from the $1.54 billion in recoveries reported in 2007 and a record $2.2 billion in 2006. But that doesn't mean federal prosecutors have let up efforts to combat health care fraud, said Russell Hayman, a partner and health care fraud expert with McDermott Will & Emery LLP in Los Angeles.

"Health care services account for roughly 16% of the nation's gross domestic product. Put that together with the fact it is so heavily regulated by the federal government and states, and you have a recipe for False Claims Act activities on the scale we've seen in recent years," he said.

Hayman attributed the relative decline in recoveries to a spate of settlements with drug and device companies in 2007. In 2006, the government pulled in a $920 million settlement with Tenet Healthcare Corp., one of the nation's largest hospital chains.

The government tallied its biggest

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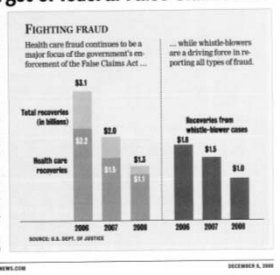

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FALSE CLAIMS ACT

- Signed in to law by President Lincoln, the original law was intended to prosecute those defrauding the Union government – selling sawdust instead of gunpowder
- Since 1986, when the Federal False Claims Act was revamped, the US government has recovered $15 billion under the Act: health care cases predominated
- Treble damages as well as civil penalties of $5000 to $11,000 for each false claim
- In fiscal 2005 (ending Sept. 30), the US recovered $1.4 billion - $1.1 billion was health care related

Virginia Medical Law Report, January 2006

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FALSE CLAIMS ACT

- Whistleblowers awarded $166 million in 2005
- The standard for a whistleblower to receive and award is that they must provide "unique knowledge" of activities or conduct in which they were not involved
- A whistleblower or "relator" receives between 15 and 30% of amount recovered
- Some state and local governments have a version of the act

Virginia Medical Law Report, January 2006

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QUI TAM

"Qui tam pro domino rege quam pro se ipso in hac parte sequitur"

Latin for:

"He who brings an action for the king as well as for himself"

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Joint Health Care Fraud Prevention and Enforcement Action Team - "HEAT"

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General (DOJ) and the Secretary of the Department of Health and Human Services (HHS)
- In FY 2013, set new records for recoveries ($4.3 Billion), Health Care Fraud and Abuse (HCFAC) Program Report ("Fraud Report")
- HCFAC recovered $25.9 billion since inception in 1997

http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

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Joint Health Care Fraud Prevention and Enforcement Action Team - "HEAT"

- Strike force set records in number of cases filed (137), individuals charged (345), guilty pleas secured (234) and jury trial convictions (46) – an average of 52 months in prison for those sentenced in 2013
- Justice Department opened 1,013 new criminal health care fraud investigations: 1,910 potential defendants, 718 defendants convicted of health care fraud-related crimes during the year, 1,083 new civil health care fraud investigations opened

http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

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CMS Recovery Audit Program

Mission: …to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers ……..

Background - ….. product of a successful demonstration program that utilized Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states…..between 2005 and 2008 and resulted in over $900 million in overpayments being returned to the Medicare Trust Fund and nearly $38 million in underpayments returned to health care providers. …. Congress required the Secretary of the Department of HHS to institute ….a permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B ……

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

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Recovery Audit Contractors (RACs)

- Recovery Audit Contractors (RACs):
  - 4 regional agencies
  - Detect and correct improper payments
  - Paid contingency fees based on amount corrected - for both overpayments and underpayments (9% - 12.5%)
  - Maximum look-back period is 3 years
- Comprehensive Error Rate Testing (CERT) program:
  - Overall rate in 2012: 8.5% or approx. $ 29.6 billion
  - Medicare Part A: 5.7%
  - Medicare Part B: 9.9%

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OPERATIONAL CONSIDERATIONS

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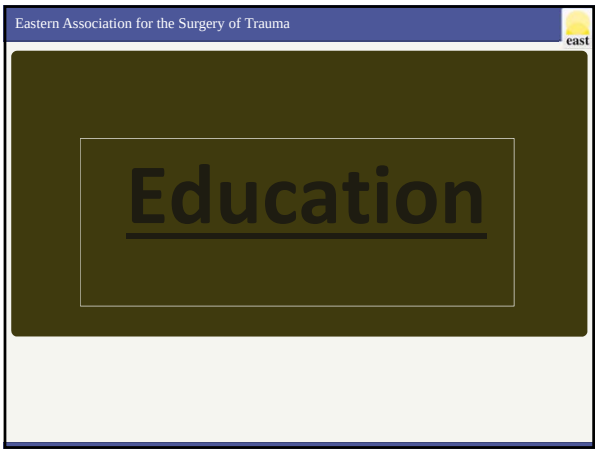
THE CHALLENGES

- **Optimize reimbursement while staying within rules**
  - **Education:** physicians, coders, billing office
  - **Operational Implementation:**
    Documentation strategies: forms, templates, EMR and EHR, helpers for the docs
    Coding strategies: coders interacting with MDs
    billing and collections: taming the beast
  - **Surveillance and Evaluation:** reports, audits, critical reviews, analysis and re-engineering
  - **Motivation:** rewards, "punishment", competition, a means to an end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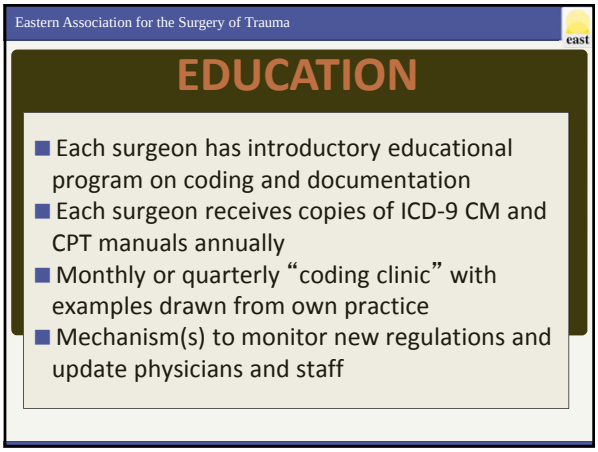
Education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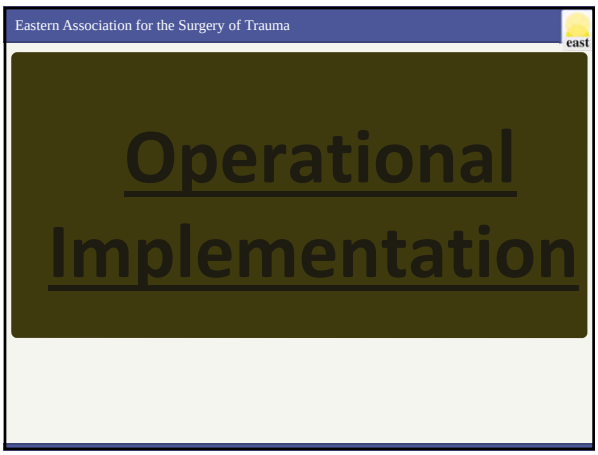
EDUCATION
Each surgeon has introductory educational program on coding and documentation
Each surgeon receives copies of ICD-9 CM and CPT manuals annually
Monthly or quarterly "coding clinic" with examples drawn from own practice
Mechanism(s) to monitor new regulations and update physicians and staff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Operational Implementation

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THE "MANUAL" APPROACH

"CLINICAL"

- Surgeon makes rounds, documents encounter
- Standardized H&P, critical care and progress notes, procedure note ("universal")
- Surgeon records diagnoses and charge codes
- Surgeon completes rounds and meets with coder
- Coder records surgeons activity and diagnoses
- Coder asks necessary questions or later sends an email or hardcopy query

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COMPUTER TECHNOLOGY

- Facilitates billing, coding and documentation:
  - Legible medical records
  - Lists of diagnoses and procedure codes
  - Data capture
  - Ability to review performance
- Automation: eg documentation leads seamlessly to suggested billing codes and paperwork
- Efficiency: eg one-time data entry for multiple purposes eliminates redundancy

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COMPUTER TECHNOLOGY

- Technology now available to accomplish goals:
  - Electronic health records
  - Network technology
  - Handheld devices
  - Voice recognition technology-digital recording
  - Intranet/Internet connectivity
  - RF Transmission
  - Secure servers, relational databases
- Prices are falling while computing power increases

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Surveillance and Evaluation

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SURVEILLANCE

"ADMINISTRATIVE"

- Coder prepares weekly batches, submits to billing office
- Audits: External and Internal
  Internal audits of areas of focus or problems such as 99291, consults, 99233, bedside procedures
- Update $$ list – fee schedule
- Monthly report by practice/surgeon: charges, collections, A/R
- Review explanation of benefits (EOBs) and generate denials report and meet with financial/billing director

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SURVEILLANCE

- Always appeal denied or low reimbursed claims with the carriers
- You never realize how bad your documentation is until your facility is audited

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Motivation

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MOTIVATION

"REWARDS"

- Value clinical productivity in your department
- Recognize physicians and coders who are high producers
- Recognize physicians who are in high compliance
- Tie clinical productivity to income
- As productivity increases, life should become better: hire more docs, mid-level providers, staff; more CME money; more toys; better scheduel

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MOTIVATION

"PUNISHMENT/COMPETITION"

- Set performance goals as part of job description
- Hold underperforming physicians accountable
- Show each surgeon how s/he is doing in comparison to others in group
- Take action when an individual consistently under-performs
- Prepare to thoughtfully address concerns about the "*almighty RVU*" vs *"some people are not doing their share"*

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GLOBAL SURGICAL PACKAGE

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Global Period

- RVU table published annually by CMS also identifies "Global Days" associated with procedures
- Global package derived from surgical tradition of providing post-operative care
- Adoption by Medicare carriers in 1980s
  - Variable definitions
    - Services included in global surgery
    - Duration of surgical period

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Global Period

- National global surgery policy (HCFA) became effective for surgeries performed on and after January 1, 1992
- Defined services included in global surgical period
  - Concept of "Routine" postoperative care
- Different global periods for different procedures
  - 90 days
  - 10 days
  - 0 days
  - "YYY" – variability in global period can be determined by carrier
- ***Critical Care is specifically not included as a component of the Global Surgical Package***

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Global Period

- ICD-9 provides over 15,000 diagnostic codes
- **Global fee** concept excludes all services related to the operation within 90 days
  - *Only the operation and the operative diagnoses are affected*
- Conditions with non-operative diagnoses require services not covered by the global fee
- Key is to employ separate diagnoses and modifiers to indicate unrelated services (-24, -79)

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Billing During the Postop Period: Modifiers!!

- Modifiers used to indicate that the underlying assumptions about a charge are altered
- In the case of global surgical package, modifiers indicate charges for services that should ***not*** be considered part of the global package
- HCFA/CMS Carriers' Manual states that global fee does not include:
  - Treatment for states unrelated to surgery diagnosis
  - Treatment for underlying conditions
  - Added course of treatment that is not part of normal recovery from surgery

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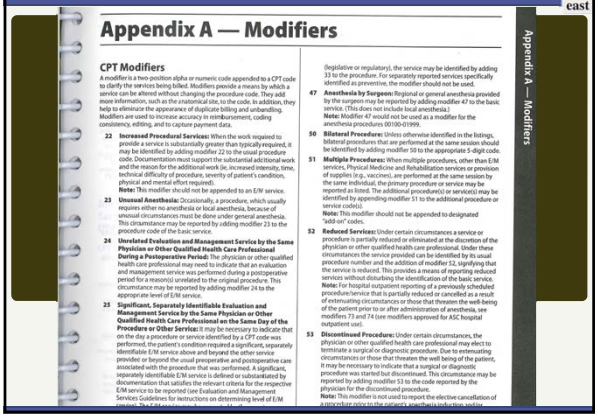

Appendix A — Modifiers

CPT Modifiers

A modifier is a two-position alpha or numeric code appended to a CPT code to clarify the services being billed. Modifiers provide a means by which a service can be altered without changing the procedure code. They add more information, such as the anatomical site, to the code. In addition, they help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data.

22 **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).
Note: This modifier should not be appended to an E/M service.

23 **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 **Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service:** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M

(legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

47 **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)
Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

50 **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

51 **Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).
Note: This modifier should not be appended to designated "add-on" codes.

52 **Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 **Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.
Note: This modifier is not used to report the elective cancellation of a prescribed procedure prior to the patient's anesthesia induction (and/or

Appendix A — Modifiers

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Billing During the Postop Period: Modifiers!!

- Postoperative period modifiers:
  - "-24" if you're billing for an unrelated E&M service in global period (not day of surgery)
  - "-25" if you're billing for an unrelated E&M service in global period (day of surgery)
  - "-57" if you're billing for a decision for surgery on same day as the surgery (ie in global period)
  - "-79" if you're billing for an unrelated procedure
  - "-78" if you're billing for a related procedure

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Billing During the Postoperative Period: *Illustration*

- Patient seen in your office in consultation for a colon lesion on Monday
- Undergoes left hemicolectomy on Thursday
- On Friday, develops aspiration pneumonitis and is intubated and admitted to ICU
- You provide the ICU care (99291) and provide good chart documentation
- The ICU care should be billed with a -24 modifier ("unrelated E&M during post-operative period") to justify E&M charge in global period

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Specialty Codes

- 65 Specialties Defined by Medicare
  - includes Midwives, CRNAs, PAs & NPs
- Each physician can be defined as only one primary specialty code for Medicare reimbursement
  - General Surgery: 02
  - Neurosurgery: 14
  - Orthopedic Surgery: 20
  - Vascular Surgery: 77
  - Critical Care: 81
  - Surgical Oncology: 91
- No Trauma Specialty Code!!

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Specialty Codes

- Physicians may choose one primary and one secondary code
- Physicians considered the same individual when providing care for a single patient if:
  - They comprise same provider group AND
  - They have the same Specialty Code
- Billing during the global package period for a patient requires a modifier for services provided by physicians sharing the same Specialty Code

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Critical Care Services During the Global Period

K. Global Surgery

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and

Medicare Claims Processing Manual

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L. Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

Postoperative

Postoperatively, in order for critical care services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or

general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

Medicare Claims Processing Manual

Examples of patients whose medical condition may warrant critical care services:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Medicare Claims Processing Manual

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CRITICAL CARE

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CODING FOR CRITICAL CARE SERVICES

- Care rendered to critically ill or injured patients under specific conditions may qualify for a critical care E&M code
- Time based code: 99291 for first hour (30-74 min)
  99292 for each subs. 30 min
- RVU = 4
- Historically: confusion and disagreement over proper use of critical care codes

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CRITICAL CARE CODING UPDATE: "Rudolph Memo"

- In December 1999, HCFA issued a "Program Memorandum" to its carriers
- Intent was "to clarify a number of issues related to the interpretation, reporting and payment" of critical care codes 99291 and 99292
- Effective January 1, 2000
- Similar to the "Cusick" memo of 1995 clarifying almost identical issues
- **DIFFERENCE:** AMA CPT 2000/2001 definitions for critical care codes (99291-99292) were changed

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Y2K CPT GUIDELINES FOR CRITICAL CARE CODES

- Enhanced/expanded definition of Critical Care:
  - no longer includes "unstable"
  - no longer has "constant attendance/attention" *but still requires MD to devote "his/her full attention to the patient and therefore cannot provide services to any other patient during this period of time"*
- 30 minutes is now sufficient for 99291 (in past 31 minutes or more required)
- Continues to require documentation of amount of time spent caring for and/or coordinating care of critically ill or injured (includes time with family on floor or unit but not time on the phone elsewhere)

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Y2K GUIDELINES 99291

- HCFA memorandum to carriers specified three criteria for acceptable 99291 coding:

  1) **Clinical condition criterion:** "*There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently*"

  2) **Treatment criterion:** *Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition*

  3) **Documentation of time**: "*Critical care time: 45 minutes excluding procedures*"

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CASE STUDY

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CASE STUDY

- 65 yo male brought to ED with BP 80 and multiple injuries: CHI, ruptured spleen, bilateral femoral shaft fxs, left hemopneumothorax ("Hurt Bad")
- You are present and direct initial resuscitation including femoral line and chest tube placement by your residents

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QUESTION #1

Acceptable charges in E... Trauma bay include:

- 9924x (outpatient consultation)
- ✔ 9928x (Emergency Room)
- *or* ✔ 9922x (inpatient admission)
- *or* ✔ 99291 (critical care code)
- *and* ✔ 36556 (central line, percutaneous)
- *and* ✔ 32020 (tube thoracostomy)

Outpatient consult only if:
- patient discharged from ED
- you do not take over care
- you communicate with requesting MD

Works but likely used by ER doc

Some carriers consider 36556 part of 99291. However, CPT manual specifies which codes part of 99291and 36489 not one of them

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Diagnosis & Procedure Match-Up

- 99291 (Critical Care CPT code)
  - 958.4 : Traumatic shock
  - 850.0 : Concussion w/o LOC
  - 865.04: Ruptured spleen
  - 821.01: Femoral shaft fracture
  - 860.4 : Hemopneumothorax
- 32020 (chest tube CPT code): 860.4
- 36556 (central line CPT code): 958.4

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CASE STUDY

- Patient goes to OR, and you assist your resident in performing a splenectomy
- You also find a ruptured small bowel loop and repair it primarily
- Orthopedics rods the femurs
- Neurosurgery places an ICP monitor

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QUESTION #2

- Acceptable charges for Op. Procedure include:
  - 49000-51 (exploratory laparotomy), 38100-51 (splenectomy), and 44602 (small bowel repair)
  - ✔ 38100 and 44602-51
  - *or* ✔ 38100-22, 44602-51
  - 38100-51, 44602
  - none, unless you personally perform entire procedure

Modifiers
-22 Difficult cases, Obesity, Shock
-51 Multiple procedures

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Diagnosis & Procedure Match-Up

- 38100-22 (Splenectomy with modifier for Unusual Procedural Services)
  Diagnosis 865.04 (ruptured spleen)
- 44602-51 (Intestinal repair with modifier indicating secondary procedure of multiple procedures)
  Diagnosis 863.29 (intestinal injury)

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REQUIRED FOR 22 MODIFIER

Most payors require supporting documentation to be submitted with the claim. Consider a cover letter justifying the increased charge in addition to a copy of the operative note!

- Increased risk
- Difficult procedure
- Hemorrhage
- > 600 ml EBL
- Extended services
- Contamination control
- Unusual findings
- Complications
- Prolonged operation
- Obesity
- Severe respiratory distress

American Academy of Procedural Coders Independent Study Prog. Module 2 3-3 to 3-4, 1996.

From the Desk of the Medical Director: -22 Modifier. Medicare Part B Newsletter No. 00-001, October 11, 1999

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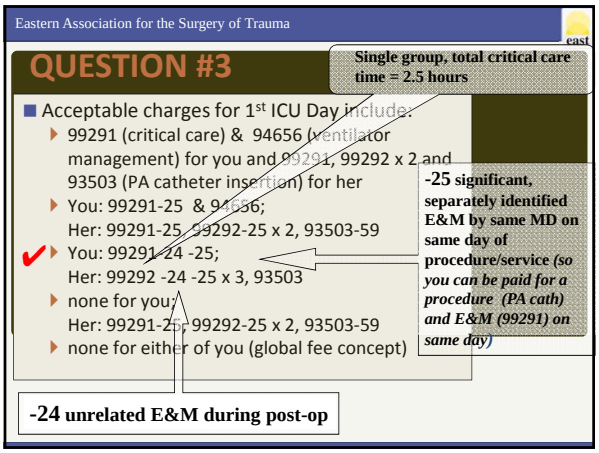
CASE STUDY

- Patient brought to ICU with BP 80 and hypoxemia
- You are personally at bedside for 31 minutes managing resuscitation and ventilator
- You go home to rest/see family and sign out to your partner who is covering the ICU
- She places a PA catheter and is at bedside for 2 hours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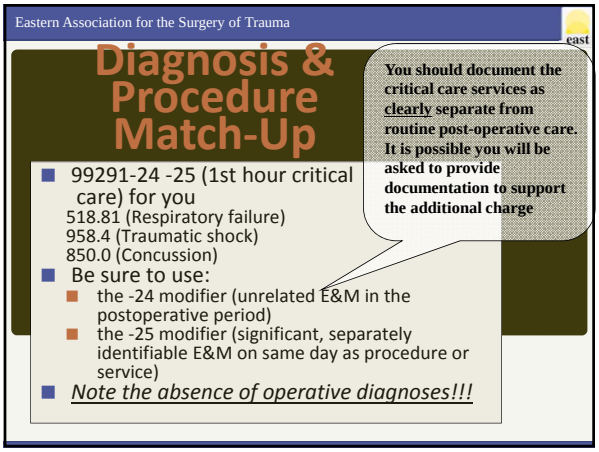
QUESTION #3
Single group, total critical care time = 2.5 hours
Acceptable charges for 1st ICU Day include:
99291 (critical care) & 94656 (ventilator management) for you and 99291, 99292 x 2 and 93503 (PA catheter insertion) for her
You: 99291-25 & 94656;
Her: 99291-25, 99292-25 x 2, 93503-59
You: 99291-24 -25;
Her: 99292 -24 -25 x 3, 93503
none for you;
Her: 99291-25, 99292-25 x 2, 93503-59
none for either of you (global fee concept)
-25 significant, separately identified E&M by same MD on same day of procedure/service (so you can be paid for a procedure (PA cath) and E&M (99291) on same day)
-24 unrelated E&M during post-op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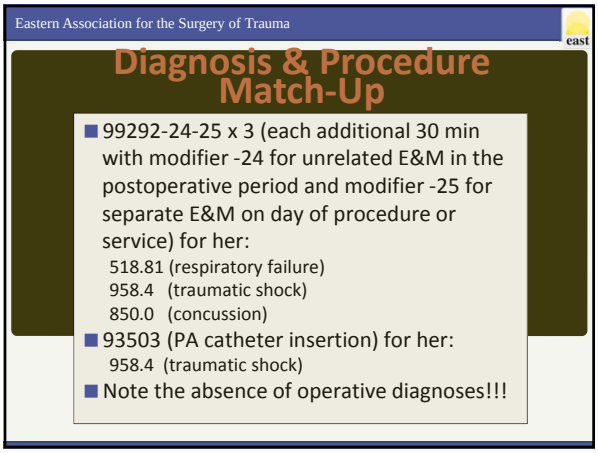
Diagnosis & Procedure Match-Up
You should document the critical care services as clearly separate from routine post-operative care. It is possible you will be asked to provide documentation to support the additional charge
99291-24 -25 (1st hour critical care) for you
518.81 (Respiratory failure)
958.4 (Traumatic shock)
850.0 (Concussion)
Be sure to use:
the -24 modifier (unrelated E&M in the postoperative period)
the -25 modifier (significant, separately identifiable E&M on same day as procedure or service)
Note the absence of operative diagnoses!!!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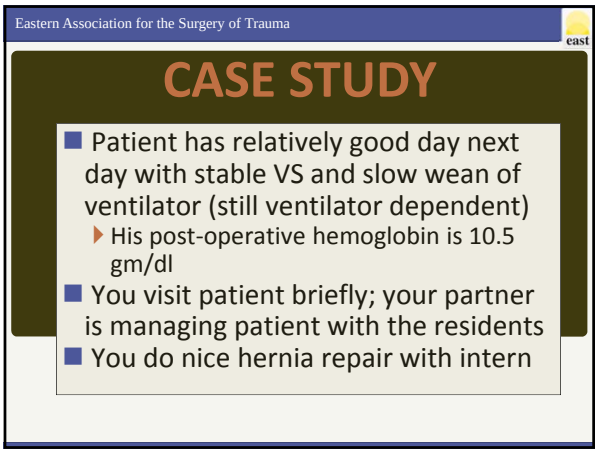
Diagnosis & Procedure Match-Up
99292-24-25 x 3 (each additional 30 min with modifier -24 for unrelated E&M in the postoperative period and modifier -25 for separate E&M on day of procedure or service) for her:
518.81 (respiratory failure)
958.4 (traumatic shock)
850.0 (concussion)
93503 (PA catheter insertion) for her:
958.4 (traumatic shock)
Note the absence of operative diagnoses!!!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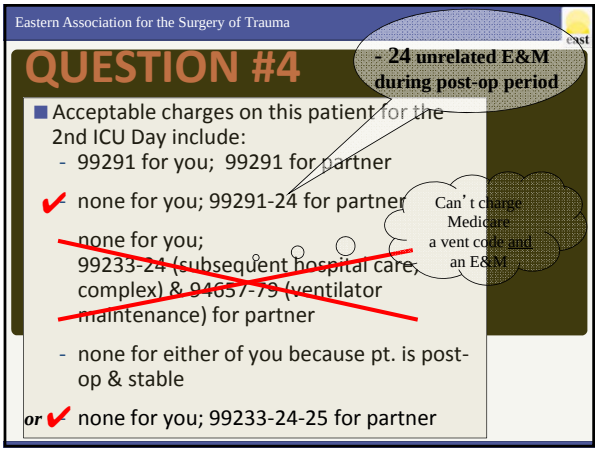
CASE STUDY
Patient has relatively good day next day with stable VS and slow wean of ventilator (still ventilator dependent)
His post-operative hemoglobin is 10.5 gm/dl
You visit patient briefly; your partner is managing patient with the residents
You do nice hernia repair with intern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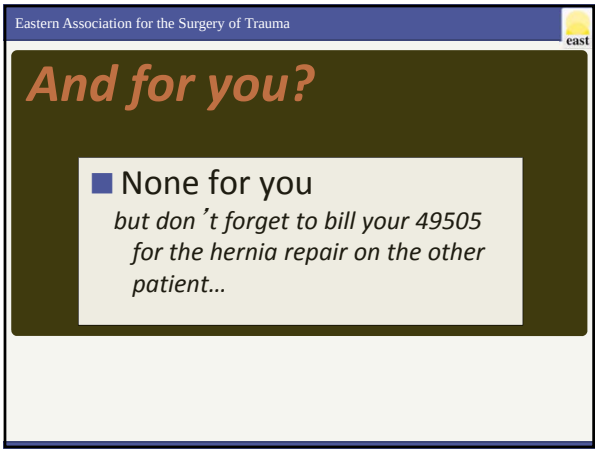
QUESTION #4
- 24 unrelated E&M during post-op period
Acceptable charges on this patient for the 2nd ICU Day include:
- 99291 for you; 99291 for partner
✔ none for you; 99291-24 for partner
Can't charge Medicare a vent code and an E&M
none for you; 99233-24 (subsequent hospital care, complex) & 94657-79 (ventilator maintenance) for partner
- none for either of you because pt. is post-op & stable
or ✔ none for you; 99233-24-25 for partner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And for you?
None for you
but don't forget to bill your 49505 for the hernia repair on the other patient…

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Diagnosis & Procedure Match-Up

- 99291-24-25 for your partner (subsequent hospital care, complex) with:
  -24 for Unrelated E&M Service by the Same Physician During a Postoperative Period
- And ICD-9 codes:
  - 518.81 (Respiratory failure)
  - 850.0 (Concussion)
  - 285.1 (Acute post-hemorrhagic anemia)

****Must be supported by documentation***

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CASE STUDY

- On third day you take patient back to OR for acute onset peritonitis
- You repair a missed small bowel injury and place feeding jejunostomy
- You feel badly and advise family immediately

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QUESTION #5

-78: Return to the Operating Room for a Related Procedure During the Postoperative Period

- Acceptable charges for 2nd Op Proc include:
  - 49002-78-51 (reopening recent ex lap), 44602-78 (repair small bowel lac) 44015-78-51 (feeding jejunostomy)
  - 49002, 44602, 44015
  - ✔ 44602-78 and 44015-51-78 only
  - no charge since it's a missed injury

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Diagnosis & Procedure Match-Up

- 44602-78 (Repair small bowel laceration with modifier for Return to the Operating Room for a Related Procedure During the Postoperative Period)
  - Diagnosis 863.29 (intestinal injury)
- 44015-51-78 (Feeding jejunostomy with modifiers for multiple procedures and for return to OR during postop period)
  - Diagnosis 560.1 (paralytic ileus)

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CONCLUSIONS

- Proper billing for E&M services and procedures requires documentation and coding of separate and distinct diagnoses
- Most patients have several diagnoses (and codes) that can be used for coding in the global period
- Use of modifiers helps to ensure that your billable services are not denied payment on their first submission

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CONCLUSIONS

- Critically ill and injured patients require more care in the peri-operative period than patients undergoing similar operative procedures who do not require critical care (i.e., elective splenectomy vs. splenectomy for trauma)
- Payment for such services is appropriate with supporting documentation

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CONCLUSIONS

- Optimal financial outcomes require:
  - ✓ an understanding of the coding system
  - ✓ personal involvement in billing - "billing at the point of care"
  - ✓ timely preparation and submission of charges
  - ✓ staying current regarding rules and regulations
  - ✓ strong documentation
  - ✓ delivering high quality care

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RESOURCES

- CMS web site: **www.cms.gov**
- American College of Surgeons: **www.facs.org/ahp/pubs/tips**
  ACS Coding Hotline **1-800-ACS-7911 (227-7911)**
  ACS ICD-9-CM and *CPT Coding Workshops.*
- AMA CPT manual.
- Brett A. New Guidelines for Coding Physician's Services - A Step Backward. NEJM 1998; 339:1705-08. (Editorial: E&M Guidelines-Fatally Flawed., NEJM 1998; 339:1697).
- Fakhry SM. Billing, Coding & Documentation in the Critical Care Environment. Surg Clin N Am 80:1067-83, June, 2000.
- Yealy DM, Fakhry SM. Documentation, Coding, Compliance, and EMTALA. In The Trauma Manual: Trauma and Acute Care Surgery (3rd Ed), Peitzman AB et al (Eds.), 2008, Wolters Kluwer - LWW, 2008, pp 121-130.

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RESOURCES (continued)

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- Medicare Learning Network (MLN) Matters, Number: MM5993, Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292).
- "Rudolph Memo": PROGRAM MEMORANDUM CARRIERS, Department of Health and Human Services, Health Care Financing Administration, Transmittal No. B-99-43, Date DECEMBER 1999, Change Request 1029, SUBJECT: Issues Related to Critical Care Policy.

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Thank you!

fakhry@musc.edu

Dealing with a Malpractice Lawsuit: What your attorney wants you to know and do

January 13, 2015

Spencer L. Studwell, Esq.
University of Rochester Medical Center

UNIVERSITY of ROCHESTER

Today's Agenda

- Strategies for avoiding adverse outcomes
- Strategies for minimizing the risk of a bad outcome becoming an asserted claim
- What to do/what not to do if you get sued

Current State of U. S. Medical Malpractice Claims and Insurance

- Frequency declining in some jurisdictions
- Severity continues to rise, driven primarily by the cost of health care
- Malpractice lines of insurance continue to be profitable for commercial market
- Capacity is good, which helps with pricing – but still not cheap!

3

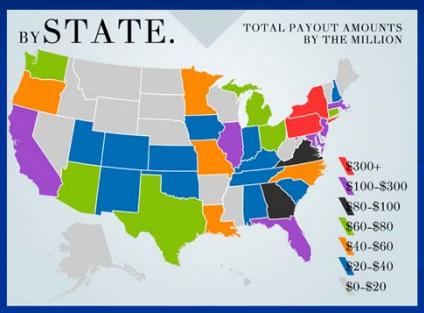
National Benchmark Data – Annual Aon Report on Hospital Professional Liability

- Aon Experience:
- 85,000 claims
- > $10 billion in incurred losses; 1200 facilities nationwide
- Includes reported losses from alternative market (captives)

- 2013Report Conclusions:
  - Frequency remains flat (0%)
  - Average size of claims is increasing 2.7% annually

Year	Severity Trend Index
2004	8.0%
2005	6.4%
2006	6.0%
2007	3.0%
2008	3.0%
2009	3.0%
2010	4.0%
2011	3.0%
2012	3.0%
2013	2.7%

Malpractice Payouts 2013 By State



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Medical Malpractice 101

- Legal Definition: failure of a health professional to practice in accordance with the accepted standards of care, resulting in patient harm.

- Practical Definition: if a medical error results in harm, and the error should have been avoided, the practitioner responsible for the error was negligent and may be held liable

Plaintiff's Burden of Proof

- To prevail in a malpractice lawsuit, the injured patient must prove that:
  - the practitioner owed the patient a duty of care;
  - the practitioner breached the duty;
  - the breach caused the alleged injuries; and
  - that the patient sustained compensable damages as a result.
- Plaintiff has the burden
- Defendant has no *legal obligation* to prove anything
- Plaintiff must prove all four elements "beyond a preponderance of the evidence"

Causation

- Departure must be "*a* proximate cause" of the patient's injury ("a substantial factor in bringing about the result")
- Not "the" only cause
- All three elements (departure/causation/injury) must be proven
  - Departure without causation: claim fails
  - Unfavorable result, but no departure: claim fails
- Is there a causation defense to the case?
  - did the events at issue contribute substantially to the patient's current condition?

Expert Testimony

- Qualifications will vary
- Board Certification not always required
- Evidence basis for opinions should be required, but is often ignored
- NY State:
  - Identity of expert not disclosed until trial
  - Depositions of experts not usually available
  - Experts cannot be cross examined based on medical literature unless they acknowledge the literature as "authoritative"
- Highly variable interest by specialty boards in policing expert activity

Damages

- Jury decides whether to award – and how much
- Compensatory - to "make the patient whole"
  - Economic - cost of needed medical care; value of "lost wages"
  - Non-economic - pain and suffering
- Demographic factors and needs affecting economic damages:
  - Age
  - Marital status
  - Parental status
  - Employment status
  - Need for future care, services, therapy, medication, equipment.
  - "Pain and suffering" and economic damages are independently assessed.

Preventing Adverse Outcomes

- Focus on Patient Safety – for example:
  - Use of checklists to avoid preventable errors
  - Team training for better perioperative communication
  - Standardized approach to handoffs

Closed Claim Reviews of Medical Malpractice Lawsuits

- Adverse Outcome – 98%
- Deviations from Standards of Care – 60%
- Suboptimal interpersonal relationship between physician and patient – 55%
- Documentation issues – 70%
- Poor communication between practitioners – 50%

Preventing a bad outcome from becoming a malpractice case

- Most malpractice cases involve missed opportunities in these critical areas:
  - Documentation
  - Communication
  - Relationship building

Common Documentation Problems that Contribute to Malpractice Losses

- Failure to document appropriately
  - failure to communicate critical information effectively
  - failure to accurately describe the plan of management
  - documenting in a way that makes the provider an attractive "target" for cross examination
    - critical of others
    - reflecting lack of necessary knowledge

Significance of Chart At Trial

- Chart is single-most important piece of evidence
  - memories fade, but are preserved by the chart
  - contemporaneous and objective
    - made at the time of treatment
    - often made before "bad outcome" known; always before the lawsuit was filed
    - you are admittedly an interested witness - but "the records don't lie"
  - tangible
    - jury takes chart into deliberation room
    - key pages become poster-sized exhibits

How Records are Used Adversely in the Event of a Claim

- To prove the extent of the injury.
- To sequence the events leading up to injury, and place blame.
- To show failure to use available information
- To show failure to share information
- To show failure to write, or failure to follow, clear medical orders.

How Records Can be Used in the Affirmative Defense of a Claim

- Documents "what really happened"
- Captures the rationale for care provided, or not provided
- Highlights the coordination of care among professionals
- Demonstrates the intelligence, skill and compassion of the care givers - how much they care.

Your Records May be More Important than Your C.V.

- Trial appearance is a job interview.
- The Job? - the Juror's Care Giver.
- Records say what kind of practitioner you are.

Other Tips for Documenting to Avoid Malpractice Risk

- "If it's not written down, it didn't happen."
- If it's relevant to patient care decision making, it needs to be recorded
  - explain the rationale for medical judgments
- "When there is no recorded continuity of the patient's care and deterioration occurs, an absence of documentation can support a claim of negligence."

Examples of Situations Where Detailed Documentation is Particularly Important

- Handoffs
  - - was the right information communicated?
- Unexpected situation or negative outcome
  - - did we recognize the problem in a timely way and take appropriate steps in response?
- Decisions not to follow a consult's advice
  - - did we show awareness of the consult's recommendation, and a reasonable medical basis for following a different path?
- Awareness of pertinent observations by nursing and other relevant clinical information (labs, imaging results)
  - - does the documented plan take the information into account?

Pitfalls to Avoid

- Perpetuating documentation errors by other caregivers.
  - Wrong diagnosis, wrong procedure, wrong plan
- Failure to document important information
  - lab and test results, vital signs, pt complaints
- Failure to record negative findings
  - If management is dependent on absent findings, documentation is critical

Issues related to EHRs

- Two biggest liability risks:
- Metadata
- Cut and paste functionality

Two Types of Communication Relevant to Potential Malpractice Exposure

- Communication among care givers of medical information relevant to patient care
- Direct communication with patients and their families

Communication Failures - the Most Frequently Seen Cause of Preventable Negative Outcomes

- Failure to recognize critical information
- Failure to use critical information
- Failure to communicate (share) critical information

Common Communication Failures

- Failing to listen
- Listening "selectively" (weighing input in favor of the best scenario)
- Failure to or solicit information from others w/ less experience and insight

Patient Communication Failures

- Failure to manage expectations
- Failure to develop relationships
- Failure to keep patients and families adequately informed
- Failure to explain adverse outcomes adequately and appropriately
- Frequently, malpractice claims are motivated by frustration and need for more information
- "Patients sometimes can't judge the level of care – only the level of caring."

Why do people sue?

Disappointment	Anger
Frustration	Fear

What bothers patients?

- Pain and suffering met with indifference
- Long waits with inattention
- Cursory exams
- Lack of interest as a human being
- Incomplete communication of information, leading to minimal understanding of disease process, therapeutics or follow up
- Failure to anticipate and warn of complications
- Failure to explain complications when they occur

Who Sues?

- 1% of all hospital patients are injured because of medical negligence
- Of those injured, only 3% bring suit...
- So, what motivates patients to bring suit?

Journal of the American Medical Association (JAMA)

- "Physicians who have been sued frequently are more often the objects of complaints about the interpersonal care they provide…"
- Poor communication skills leads to angry patients… and these are the ones who sue.

Study of Plaintiff's Malpractice Lawyers

- 80% of their clients cited anger with physician attitudes as reason for suit
- "Doctors who are always in a hurry"
- "Doctors who act superior to their patients"

Other Communication problems cited by these studies

- Delivering information poorly - in a callous as opposed to compassionate way
- Treating the patient as a diagnosis, instead of as a human being
- Devaluing the patient's views
- Causing the patient to feel deserted

Doing Disclosure Well

- May be the last clear chance to avoid a lawsuit
- Skillful disclosure of bad news can help prevent malpractice litigation.
- Both failure to disclose and unskillful disclosure can lead to litigation.
- Research is immature - no totally reliable "rules for disclosure" and no silver bullets

What do patients and families want??

- What *you* would want – to know:
  - "what happened";
  - The implications for their health;
  - Whether we understand how the outcome happened; and
  - If possible, how future similar problems will be prevented.

Checklist for Practitioners: What to Do if a Patient Suffers an Adverse Event

- Don't assume a bad outcome is malpractice
- Don't speculate prematurely as to the cause of the adverse outcome
- Do disclose the fact of the adverse outcome promptly
- Plan your conversation with the patient and the family carefully, with appropriate input
- In difficult cases, coordinate with the other members of the team and consider calling the risk management office for advice.

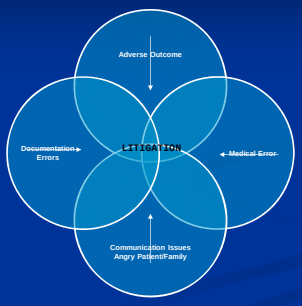
What to Include in the Disclosure Discussion

- Simple statement of regret: "I'm sorry you experienced this complication."
- Objective discussion of known facts relating to condition and treatment
- Anticipated effect on immediate and short term prognosis and care
- Clinical interventions done or planned in response to the event

The Best Advice We Can Give

- Simple Rule of Thumb: treat patients the way you would want yourself or your family to be treated.
- With dignity, compassion, respect and honesty.
- Why do it?
  - Influencing the patient at the fork in the road
  - Controlling your own destiny with regard to malpractice risk

The Perfect Storm



Better to know now – if you do get sued…

- Direct and indirect expenses may be high
- Time commitments may be significant
- Potential for related regulatory investigations and possibly professional misconduct charges
- Reporting to the National Practitioner Data Bank with potential implications for employment and credentialing
- Stressful, disappointing and emotionally draining
  - Potential for self- doubt

What to do and what not to do if you get sued

- Don't let yourself get down or overwhelmed
- Stay engaged, but go on with life
- Participate and prepare
- Issue spotting
- Architect of the Defense
- Expert selection
- Deposition
- Trial

Michael F. Rotondo MD FACS

University of Rochester
School of Medicine
and Dentistry
CEO Medical Faculty Group
Vice Dean for Clinical Affairs
Professor of Surgery

28th Annual Scientific Assembly

east

Changes in Academic Medicine:
How to Stay Ahead of the Pack

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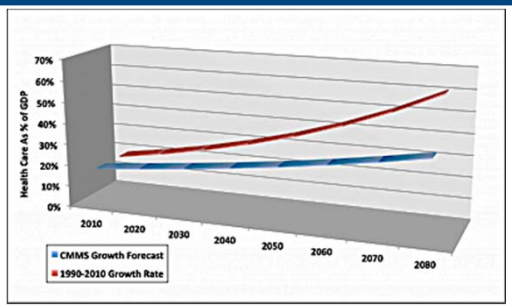
THE CURRENT ECONOMIC MODEL IS CHANGING!

Health Care Costs: Risk to the US Economy



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Objectives

- Discuss the current economic forces on health care
- Discuss the concept of "downward pressure" on surgeons
- What is the Affordable Care Act?
- What is an ACO and why does it exist?
- What should we do to respond, survive and flourish?

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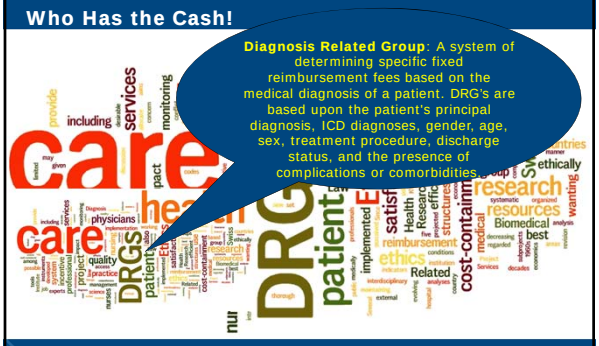
Who Has the Cash!

Diagnosis Related Group: A system of determining specific fixed reimbursement fees based on the medical diagnosis of a patient. DRG's are based upon the patient's principal diagnosis, ICD diagnoses, gender, age, sex, treatment procedure, discharge status, and the presence of complications or comorbidities.



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Where is the cash?

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Physicians at the Center of Long Standing Pressures

Academic Time

More Financial Support

Justification of Value

School of Medicine	Physician Organization	Teaching Hospital
Demand for teaching time with less funding.	Demand for clinical productivity.	Shrinking capital funds.
Research program growth.	Growing administrative responsibilities.	Volume, volume, volume.
Growing GME responsibilities.	Do more with less.	Pressure for quality outcomes.
Enrollment growth.	Request for more coverage.	Need more coverage.

The Spondulix Feedback Loop

INHIBITORS: Stark Regulations, Poor Citizenship, Lack Productivity
CATALYSTS: Unified Business Platform, Alignment

Comprehensive Federal Health Care Reform

The Catalyst that Changes Everything

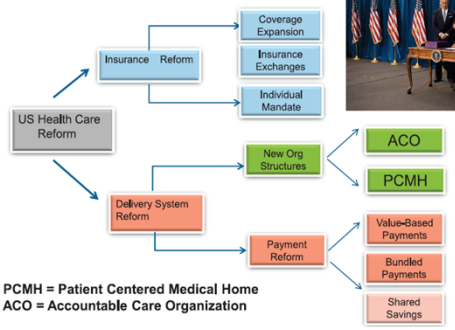
1. Spiraling Health Care **Costs**
2. Health Care **Access**
3. Uneven **Quality**
4. Changes to Health Care **Delivery System**

The Patient Protection and Affordable Care Act of 2010

US Health Reform 2010

Two-Pronged approach to Redesign of the US Health Care System.

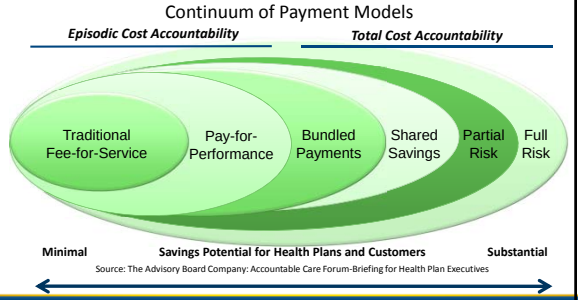
Who will Lead "Delivery System Reform"?



- PCMH = Patient Centered Medical Home
- ACO = Accountable Care Organization

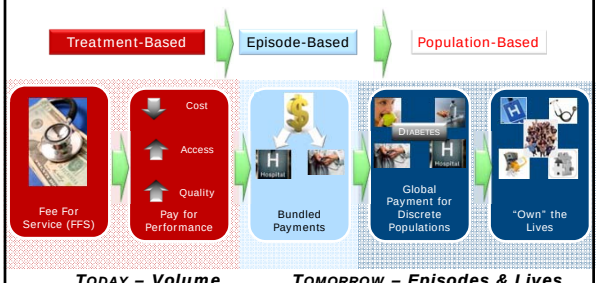
Accountability: Quality and Cost Charting the Path of Payment Reform

Continuum of Payment Models

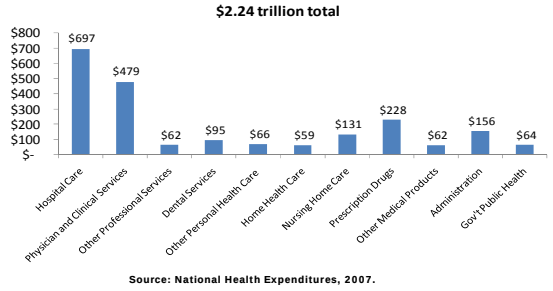


Source: The Advisory Board Company: Accountable Care Forum-Briefing for Health Plan Executives

Evolution of Healthcare Payment Structures



Bending the Cost Curve: Breakdown of US Costs by Type



Source: National Health Expenditures, 2007.

Challenges for AMCs: Competition for Rates

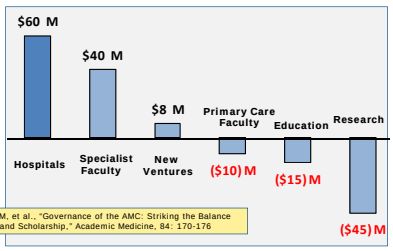
AMCs have fundamentally different cost structures than other types of hospitals due to mission related costs

Estimated Cost Per Case	Academic Medical Center	Other Teaching Hospitals	Urban Community Hospitals
Base costs	$3,974	$3,984	$3,993
Wages and case-mix costs	$2,214	$1,389	$985
IME and other mission related costs	$2,360	$674	$260
Total	**$8,548**	**$6,047**	**$5,238**

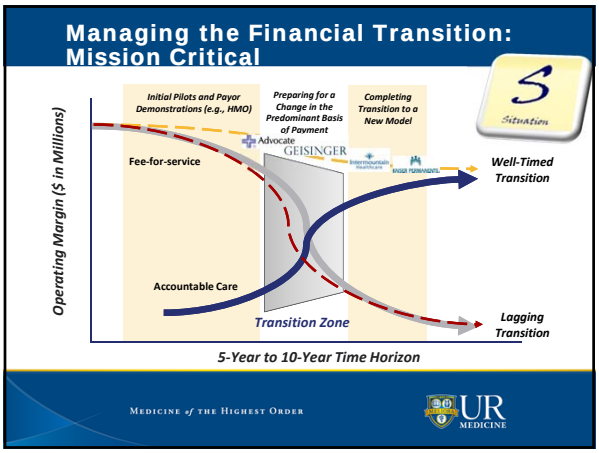
Source: Koenig L, et al., "Estimating the Mission-Related Costs of Teaching Hospitals," Health Affairs, 22: 1112-122

Academic Medical Centers: Challenges

Negative margins in research and education missions are subsidized by positive margins in hospital and specialty clinical services



Source: Wietcha M, et al., "Governance of the AMC: Striking the Balance Between Service and Scholarship," Academic Medicine, 84: 170-176


Managing the Financial Transition: Mission Critical
Situation
Initial Pilots and Payor Demonstrations (e.g., HMO)
Preparing for a Change in the Predominant Basis of Payment
Completing Transition to a New Model
Advocate
GEISINGER
Fee-for-service
Well-Timed Transition
Accountable Care
Transition Zone
Lagging Transition
Operating Margin ($ in Millions)
5-Year to 10-Year Time Horizon
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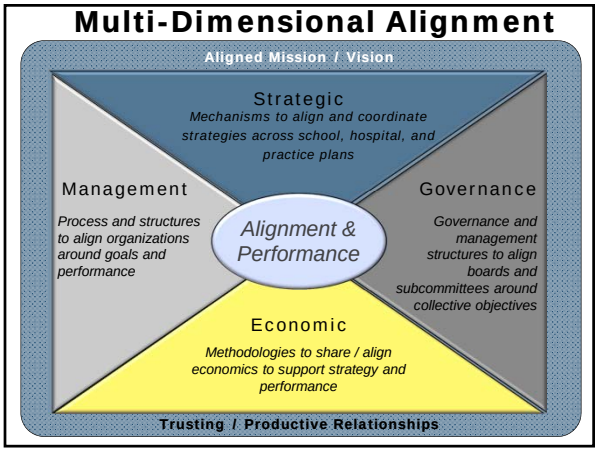
Multi-Dimensional Alignment
Aligned Mission / Vision
Strategic
Mechanisms to align and coordinate strategies across school, hospital, and practice plans
Management
Process and structures to align organizations around goals and performance
Governance
Governance and management structures to align boards and subcommittees around collective objectives
Alignment & Performance
Economic
Methodologies to share / align economics to support strategy and performance
Trusting / Productive Relationships


URMG United
Strategic Direction
Move to a fully integrated, multi-specialty group practice with URMFG leading the charge!

Integration and Identity
(Where do we want to go?)

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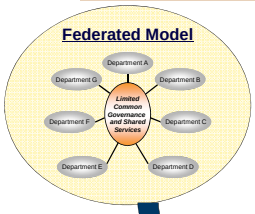
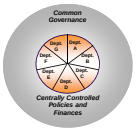
An integrated faculty group practice needed to develop a unified strategy, and strategy calls for a more integrated practice.

Federated Model



Multispecialty Model



"Billing Shop" and Independent Departments → Integrated Multispecialty Group Practice

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University of Rochester Medical Center

Major Strategic Opportunities: Change in Culture

Align Incentives

Finance	Clinical Operations	Regional Penetration	Information Technology	People and Culture
Cost Savings	Quality Safety Service	Deploy People Grow Practices	Analytics	Enterprise Thinking

Value — Accountable

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What is an Accountable Care Organization?

General definition

- A partnership among health care providers to coordinate and deliver efficient care
- Assumes joint accountability for improving quality and slowing cost growth

The PPACA Section 3022 definition

- Organization of health care providers that agrees to be accountable for quality, cost and overall care of Medicare beneficiaries who are enrolled in traditional fee-for-service program and who are assigned to it
- For each 12-month period, participating ACOs that meet specified quality performance standards eligible to receive share of any savings if actual per capita expenditures for assigned Medicare beneficiaries are sufficient percentage below specified benchmark amount

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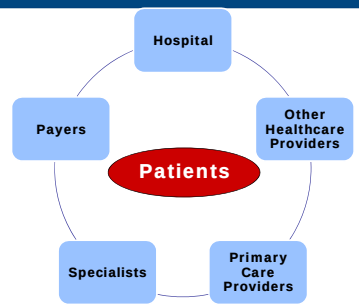
ACO Envisions Integrated Care



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Accountable Health Partners – WHY?

Optimal Quality & Cost = Optimal Risk Contracts

Scale = Population Health

Fee for Service

Fee for Value

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Accountable Health Partners

Accountable Health Partners - The Machine

- *Stabilize the Referral Market*
- *Access to Population*

Population Health Scale Builder

Accountable Health Partners

Addressing Physician Barriers to Integration

Challenges

- Overcoming physician attitudes favoring autonomy and individual accountability
- Making a strong business case for ACO development
- Overcoming resistance to capitation and potential penalties related to quality performance
- Determining appropriate reimbursement model
- Negotiating appropriate use of potential shared savings, e.g., offset revenue decrease resulting from reduction in volume or invest in care management and IT infrastructure

Legal and Regulatory Barriers

Sharing financial incentives could place providers at risk for violating federal law

- Medicare ban on self-referral
- Fraud and abuse statutes
- Anti-Kickback Statute
- Civil Monetary Penalty law

Antitrust

IRS guidelines for nonprofit institutions

Need to assess and revise existing contracts among providers

Distributing ACO Shared Savings

Tier 3	**Financial Risk:** High **Mode of Payment:** Full or partial capitation and extensive bundled payments. **Additional Incentives:** Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target.
Tier 2	**Financial Risk:** Moderate **Mode of Payment:** Fee-for-service, partial capitation, some bundled payments. **Additional Incentives:** More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target.
Tier 1	**Financial Risk:** Low **Mode of Payment:** Fee-for-service **Additional Incentives:** Some shared savings and bonuses if per beneficiary spending is below agreed-upon target.

S.M. Shortell, L.P. Casalino, and E.S. Fisher, "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations," *Health Affairs 29, no. 7 (2010): 1293-98.*

Early Results – The ACO Experiment

- Medicare Shared Savings ACOs: only 53 of the 320 participating ACOs generated savings – many faced exorbitant losses in the millions
- Pioneer ACO's: only 11 of the 23 produced savings and some dropped out all together

What about claims variation??

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Key Observations – The ACO Experiment

- Being a first mover to clinical integration is an advantage
- Costs to manage risk are significant
- Managing physician expectation and behavior is difficult, especially if the ACO loses money!
- Contracting effectively with payers is essential
- Patient Care Management is tough!

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Future Success Factors

- **Scale**
- **Integration**
  - Across medical staffs / Clinical practices
  - Medical Staff and Hospitals / Healthcare Facilities / Long Term Care / Behavioral Health
  - Information Systems
- **Provider Network** – location, accessibility, & value
- **Smart Application of Information**
  - Collect, Share, Interpret & Use Data
- **Highly efficient cost structures**
- **Best Quality & Patient Safety** in a market

Advancing the Academic Health System of the Future

- System based with a broad regional presence
- Strong and aligned governance
- University relationships will be challenged
- Enhanced Roles for Physician Leaders
- Transparency in outcomes and finances
- Operating model restructure for for cost and quality
- Movement to population health
- Revamp the organizational culture

A Report From the AAMC Advisory Panel on Health Care - 2014

Health Care Reform - Summary

What's Working?	What's Not?
•ACA is driving disparate entities together	•No plan to front the reengineering cost
•There is tremendous movement in the market	•Counterproductive competition is surfacing
•The health care system is in a relearning phase	•The legal labyrinth seems insurmountable

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