MGMA Risk Management Smart Pack 2011
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5 compliance concerns for medical practices

Posted by Matthew Vuletich on Thu, Nov 04, 2010

Is your medical practice doing all it can to comply with government regulations? You undoubtedly have this at the top of your list. But whether you have a full-time compliance officer, are that person, or wear many other hats during the day, compliance still needs to be a top priority.

It's no wonder then that Huron Hospital's Michael O'Connell, MHA, FACMPE, FACHE, VP operations/physician services, spoke to a packed session at the MGMA 2010 Annual Conference last week on "Staying Out of Trouble in the Top 10 Compliance Areas." The hospital is a part of the Cleveland Clinic Hospital in Ohio.

At the clinic, O'Connell said they do a number of things to work together as a team on compliance. A few of their processes include:

- Downloading and reading through the Office of Inspector General's yearly Work Plan
- Determining which issues from the OIG report to focus on that year
- Communicating with all employees the importance of identifying and addressing compliance issues at work
- Documenting key compliance strategies and procedures each year (in case of an audit)
- Monitoring an anonymous phone line and e-mail system for employees to report compliance issues

Whether you have a few – or a lot – of rules in place, it never hurts to brush up on the basics. Here are five top compliance issues and what you can do in your practice to meet the requirements.

1. Family/friends

Do you know what information about a patient may be given to family and friends? Does your staff know? Unless you're certain, only release location, general condition (stable, sick, good) or death may be given to family/friends, said O'Connell. Spouses do not have automatic rights to any information, contrary to their belief. Make sure you have a written code of conduct in your practice for this policy.

2. Recovery Audit Contractors (RACs)

When RACs audit your practice they're looking for money to return to the Medicare Trust Fund. O'Connell said the biggest challenge Huron Hospital had when it experienced a RAC audit, was ensuring they stuck to their own guidelines. This includes auditing claims no earlier than 2007 and also making sure the right professional employed by RAC was reviewing the correct information. If RACs come to call, check our RAC resource page for help.

3. Duty to report

Often, people have good intentions and don't know that what they're doing is a problem. This can include patterns of incorrect billing, misusing protected health information and sharing passwords. Or it could include something more intentional, such as fraud. Make sure employees know it is their duty to report issues. "Reporting a compliance issue isn't about getting someone in trouble," O'Connell said. It's a duty.

4. Safeguarding privacy

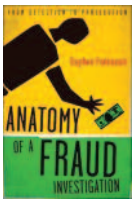
Sometimes compliance is as simple as asking someone to step back from a conversation or going into a private room. Think of privacy in a broader sense, too – not just safeguarding information from friends/family, but also other employees. Train your employees to know what information they can/can't have access to.

5. Gifts and gratuities

Patients have good intentions and are often generous with their ways of thanking employees, but it's important to form a policy that maintains your practice's credibility and impartiality. At Huron Hospital, the policy is that employees should not solicit tips, personal gratuities or gifts from patients or vendors. They may accept small tokens of appreciation, such as candy or flowers, and must submit all gifts valued at more than $50 to payroll to be figured into their compensation. "The hardest time to do this is during the holidays," O'Connell said. "It's uncomfortable. It's awkward. But we need to be able to coach employees to do this."

5 ways to mitigate risk in your practice

Policies, procedures and access to updated information will help keep your medical practice up-to-date with current trends and reduce medical management risk.



1.**Prepare for fraud before it happens**
Peppered throughout Stephen Pedneault's attention-grabbing fraud narrative in the book *Anatomy of a Fraud Investigation* are learning points and key takeaways for dealing with fradulent activity in your own business. See page 38 for the latest research from MGMA on theft and embezzlement, then grab this book to see fraud in action.

2. **Understand malpractice insurance rate trends.**
Good news for some practices: malpractice insurance rates decreased in 2008 and 2009 for some specialties, according to the 2010 *MGMA Cost Survey Report for Single-Specialty Practices*. Those specialties that decreased both years include:

- anesthesiology
- cardiology
- orthopedic surgery

Other specialties only decreased in 2009:
- general surgery
- OB/GYN

And two specialties experienced increases:
- pediatrics
- family practice

Visit mgma.com/malpracticearticle to read an *MGMA Connexion* exclusive about why malpractice rates cycle high and low and how to protect your practice.

3. **Prevent identity theft.**
In the MGMA Red Flags Rule Resource Center, you will find sample procedures, policies and a free Webinar to help prepare for the Jan. 1, 2011, enforcement date.
mgma.com/redflagsrule

4. **Promote patient/provider communication.**
The strongest predictor of an individual's health status is not age or income – it's health literacy, according to the Partnership for Clear Health Communication. "Ask Me 3" is the organization's patient education program that includes online resources to help providers and patients get the most out of each patient visit.
npsf.org/askme3

5. **Stay up-to-date on compliance.**
The *MGMA Washington Connexion* e-newsletter alerts you to the latest legislation and regulation changes — as they happen — from Washington, D.C. It's free for MGMA members. mgma.com/washington

Cover up

Does your practice have the right insurance coverage?

By Donna Knapp, MA, FACMPE, independently contracted consultant, MGMA Health Care Consulting Group, and administrator, Pulmonary Medicine Associates and Sierra Hospitalists LLC, Reno, Nev., donnak@pmareno.com

Managing the risk associated with your medical practice can be as simple as taking inventory of the opportunities to insure the organization against unexpected events and outcomes. Does your practice have the insurance coverage it needs to protect its business, buildings, staff, patients, visitors and shareholders?

Every medical group should have the basic insurance policies: general liability, workers' compensation and professional liability. But you can get frustrated looking at each type of policy for the most comprehensive and cost-effective coverage for the practice. Insurance brokers rarely present product comparisons in easy "apples to apples" style.

Take inventory of your practice's coverage

Take an inventory of your current insurance policies to determine whether you have gaps or excesses in coverage and to remind yourself of termination dates. The inventory can serve as an outline of the coverage you desire and a template to request bids from insurers. Compare bids to determine the ones that offer the most cost-effective policies for the coverage. Use my example of this tool, below, and modify it for the needs of your practice.

Most medical practices consider having the following types of insurance:

- General liability – Coverage includes

Group practice insurance program

Type of policy	Covers	Term	Deductible	Limits	Carrier
Commercial package	Blanket property coverage	May 1, 2009	$2,500	Building $1,700,000 Personal property $1,250,000 Business income $3,500,650 Equipment data/media $1,500,000	ABC Insurance Co.
	General liability	June 1, 2010	$1,000	General aggregate $2,000,000 Personal injury $1,000,000	
Professional liability	Medical malpractice	Dec. 31, 2009	$5,000	$1,000,000 claim/$3,000,000 aggregate	Malpractice Insurance Co.
Commercial automobile	Leased autos	April 11, 2010	$500 comprehensive $500 collision	Liability hired/nonowned $1,000,000 Uninsured motorist $1,000,000	DEF Insurance Co.
Workers' compensation	Offices in Texas, Nevada and New Mexico	June 14, 2010	No deductible	Statutory based on payroll	Workers' Compensation Insurance Co.
Commercial umbrella excess	Automobile liability, employer's liability, employee benefits liability and general liability	May 31, 2009	No deductible	$5,000,000	GHI Insurance Co.
Directors and officers	Applies only to claims first made against the insured and reported to the company during the policy year	Sept. 30, 2010	$25,000	$3,000,000	JKL Insurance Co.

Checklist to evaluate insurance for your practice

This simple tool can assist you in developing and maintaining the insurance portion of your risk management program. Keep it current, organized and concise for review and reporting to your board of directors.

Type of policy
- ☐ What types of coverage are critical to our practice?
- ☐ What types are offered as a benefit to shareholders and/or staff?
- ☐ What is required by law or contract?

Coverage
- ☐ What specific provisions does it cover? Are all practice sites *and* storage sites covered?
- ☐ What are the exclusions?
- ☐ Is there overlapping coverage that we could eliminate?
- ☐ Does the coverage keep up with our changing technology?

Term
- ☐ When are the premiums due?
- ☐ When should we review the policy for bid?
- ☐ Do we want all policies to renew at the same time?

Deductible
- ☐ What portion of a claim is our practice willing to pay?
- ☐ What do we need in reserve funds if a catastrophe occurs?

Limits
- ☐ Are the limits appropriate for the potential loss? (Most practices have not calculated the true cost of replacing valuable papers.)
- ☐ Have we performed an analysis to determine replacement costs?
- ☐ What are the historical court awards in this risk area in our state?

Carrier
- ☐ Is and has the carrier been rated highly?
- ☐ What is its service reputation?
- ☐ Have there been any delays in paying valid claims?
- ☐ Is the insurer's representative knowledgeable and helpful?

leased automobiles, valuable papers and lost revenue;

- Professional liability (medical malpractice insurance);
- Workers' compensation;
- ERISA (Employee Retirement Income Security Act) bond for fiduciary liability;
- Employment practices liability;
- Directors' and officers' liability; and
- Notary errors and omissions.

Less common in medical group practice, but worth considering may be coverage for:

- Billing and compliance liability;
- General umbrella – to bundle coverage for bodily injury, property damage, personal injury, etc., into a single policy;
- Extra fiduciary liability – further protection for managing a pension plan;
- Internet liability – for risks associated with e-business, privacy protection, virus transmission, etc.;
- Accidental death and disability;
- Long-term care;
- Officer life insurance;
- Short-term disability;
- Long-term disability; and
- Stop-gap – for defense and indemnity protection against employee lawsuits for job-related injuries.

Use the group-practice insurance program checklist above to take an organized inventory of your insurance coverage.

Keeping current with your practice's insurance policies won't be the most exciting part of your job, but it's one of the most important. And it only takes one accident, one lawsuit or one slip in compliance to bring that point home.

join the discussion: What kinds of insurance coverage does your practice have? Tell us at mgma.com/connexioncommunity or connexion@mgma.com

mgma.com

- Search: "insurance"
- mgma.com/consulting
- Store: e6672 for the electronic Information Exchange "Liability Insurance Plans"

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MGMA e-Source, July 8, 2008

Develop an effective compliance program

By John S. Cunningham, MS, MBA, FACMPE, MGMA member, and associate administrator, Holzer Clinic, Gallipolis, Ohio

Noncompliance with the myriad laws that regulate health care can pose significant risk to physician group practices. An effective corporate compliance program is a physician group's best defense against illegal business conduct.

Compliance programs come in various shapes and sizes; no single model will meet the needs of all practices. A program must be designed to meet the requirements of a specific organization, and a practice's resources will play a significant role.

When developing a compliance program, keep at the forefront the primary objective defined by the U.S. Sentencing Commission: to promote ethical conduct and establish an organizational culture of compliance.[1]

Program development must begin with a strong commitment by the organization's leaders – and permeate through all levels of the medical group. Developing a medical group's corporate compliance program takes four steps:

1. Identify the need for a proactive approach to compliance.

2. Gain the formal commitment of the governing authority. This involves a directive to pursue a compliance program as a matter of policy and leaders' commitment to support the effort with adequate resources.

3. Appoint a corporate compliance committee. Its members should represent various aspects of the organization to ensure comprehensive compliance efforts. The organization's general counsel often sits on the compliance committee, which is responsible for assigning a corporate compliance officer, who typically serves as the committee chair.[2]

4. Provide a charge to the compliance committee. This comes from the practice leaders. The committee must use the resources allocated to structure the compliance effort.

Formal compliance program components include the compliance committee, policies and procedures, education and training, and disciplinary parameters. The substance of a program encompasses the areas of concern covered by the OIG work plan, antikickback and antitrust issues, illegal referrals and billing fraud.[3] Both the structure and the substance must be monitored for effectiveness.

An effective corporate compliance program makes an organization consciously consider the legal and ethical operation of its business on an ongoing basis. Each practice must personalize its program, assess areas of risk, allocate resources and create a culture of compliance. This is no small task – but it is essential for long-term operational success and quality care.

Notes

1. Desio P, Steer J. U.S. Sentencing Commission update. Paper presented at the meeting of the Health Care Compliance Association's Annual Compliance Institute, New Orleans, April 19, 2005.
2. Centers for Medicare & Medicaid Services. March 2005. Compliance Program Guidance for Medicare Fee-For-Service Contractors.
3. Steiner J, Wollschlager E. Compliance program month-end strategies for organization-wide accountability. Paper presented at the meeting of the Health Care Compliance Association's Annual Compliance Institute, April 18, 2005, New Orleans.

Defining Your Profession

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MGMA e-Source, Feb. 26, 2008

Develop an effective risk-management program

By Kerri J. Gantt, LHRM, CMM, FACMPE, MGMA member, administrative director, Gastroenterology Associates of SW Florida PA, Fort Myers

Everyone in a medical group practice benefits from an effective risk-management program. A strong program helps identify problem areas and enables clinicians to reduce patient errors and poor outcomes. To accomplish this, leaders — including the practice administrator — must constantly gather pertinent information. This allows you to develop policies and procedures that promote quality health care and a safe environment.

The basic components of a risk management program are a source document to report incidents, staff education and a quality-improvement team.

The source document, known as the incident report, is the most important communication link. It supports the entire risk-management program by recording the facts related to the incident. The document should contain:

- The name of the party involved in the incident;
- The date and time of the occurrence;
- The description of the event;
- Any equipment involved;
- The name of those involved in the incident; and
- The names of any witnesses.

Examples of when to use an incident report include:

- Falls;
- Medication-related occurrences (including near-misses);
- Allergic reactions (e.g., to food, drugs, dyes);
- Equipment failures or improper use of equipment resulting in injury;
- Improper consent;
- Lost or broken valuables;
- Patient leaving or signing out against medical advice;
- Unanticipated patient outcome;
- Misdiagnosis; and
- Wrong patient treated or wrong procedure performed.

Staff education is a key element of a successful program. Risk management is not an isolated event, but rather a continuous part of patient care and safety. Each employee contributes to the program's success. Staff education must include what, when and how to report.

Certain incidents may require additional reporting to the state:

- Death;
- Brain or spinal damage;
- Permanent disfigurement;
- Fractures or dislocations;
- Neurological deficits; and
- Procedures performed without informed consent.

Train staff to report an incident promptly, while memories of events surrounding the incident are clear. Emphasize that staff report life-threatening incidents immediately.

A quality-improvement team is the third major component of a practice's risk-management program. The team should be multidisciplinary – the quality improvement process benefits from information from all areas. The team is responsible for analyzing the data and spotting trends. The data should be examined in a variety of ways to evaluate all aspects of the incident and to identify trends. For example, examine the type of incident, the process involved and the caretakers involved.

The technique used to evaluate an incident is called a root-cause analysis. An organization continually looks at why something occurred so it can prevent a recurrence. It is clear that reporting incidents and using the data to effect change can result in high-quality care.

Fraud squad Rx

Document-security technologies and processes you can use to curb prescription fraud

How much is a blank prescription worth? To you, the practice administrator, probably very little; you buy them by the hundreds or perhaps get them for free.

But to a forger or drug addict, a blank prescription sheet is a gold mine. Anyone with even a basic understanding of computers can transform one blank prescription into hundreds.

That's just one factor contributing to the growing problem of prescription fraud. As many as 7 million Americans will abuse prescription drugs this year — more than the number who will use heroin, cocaine, hallucinogens, Ecstasy and inhalants combined.[1] Prescription fraud and abuse cost the U.S. health care system billions each year.

To fight prescription fraud, the health care industry is adopting document-security technologies proven in other industries. But these technologies can succeed only if they are supported by human knowledge and vigilance.

Anyone with even a basic understanding of computers can transform one blank prescription into hundreds.

The role of technology

Considering the value — and danger — that a pad of blank prescriptions poses, the Congress in 2007 passed legislation mandating that all outpatient Medicaid prescriptions be written on tamper-resistant paper.

The Centers for Medicare & Medicaid Services (CMS) require that tamper-resistant prescription blanks integrate at least three industry-recognized security features as of Oct. 1, 2008.[2]

As you go about selecting secure prescription pads for your practice, understand how document fraud is perpetrated and the role prescription pads can play in curbing it.

Look for prescription pads with copy-protection features such as fine irregular lines, microprinting, heat-sensitive inks and watermarks.

Alteration. Forgers can simply change a "1" into a "10" on the refill number, or use chemicals to wash out the name of one drug and replace it with another. The prescription pad you select should prevent alteration by using chemical stains or chemically reactive inks that void the document if an attempt is made to change it.

The pen used by prescribers can also thwart alteration. Security experts recommend using gel pens for prescriptions because paper absorbs that ink better than ballpoint pen ink.

Theft. To deter theft, consider prescription pads with control numbers that make it easy to identify when thefts occur and to track stolen pads. Evaluate the security of the company that prints and ships your prescription pads. Ambitious criminals may target printers or shipping companies to acquire large quantities of blank prescriptions.

see **Solutions, page 26**

By Frank Abagnale, Abagnale & Associates, Washington, D.C., frank@abagnale.com

Jason J. Frerichs, document security expert and director of prescription technology, Standard Register, Dayton, Ohio, jason.frerichs@standardregister.com

New York's security measures save millions in prescription fraud

In 2006, New York required that all prescriptions be written on the state's official tamper-resistant prescription forms. These forms exceed the requirements of the Centers for Medicare & Medicaid Services, with a long list of overt and covert security features to prevent copying and alteration. The state also implemented stringent ordering and processing controls to prevent theft and false issuance.

The benefits were immediate and impressive. The precautions generated more than $60 million in Medicaid fraud savings in the first six months of accounting oversight.[1] In addition, the Bureau of Narcotic Enforcement estimates the program saved $75 million in the private sector by reducing fraudulent prescription claims to health care plans.[2]

notes

1. State prescription forms reducing fraud and abuse. Press release, July 31, 2007. New York State Department of Health. www.health.state.ny.us/press/releases/2007/2007-07-31_prescription_fraud_savings.htm, accessed May 27, 2008.
2. Ibid.

Mimicry. A mimic usually attempts to represent an original item with falsified information, such as counterfeit driver's licenses, passports and checks. Creating an exact copy of a prescription with no security features is as easy as using a copier. Look for prescription pads with copy-protection features such as fine irregular lines, microprinting, heat-sensitive inks and watermarks.

False issuance. False issuance involves issuing a legitimate item under false pretenses. Perpetrated by an insider, such as a medical office employee, it's usually embezzlement. Perpetrated by someone outside the system, it's usually misrepresentation. In either case, an ill-intentioned person gains access to a legitimate item. Preventing false issuance requires increased security and vigilance by those handling prescription pads, including physicians, medical staff and pharmacists.

What health care professionals can do

Physicians must, of course, watch for patients who "doctor shop" or manufacture symptoms to acquire painkillers and other drugs. Physicians must also take care to safeguard their prescription pads.

In most practices, you're the one who chooses prescription pads and implements policies and procedures that discourage theft, such as:

- Counting stock at regular, unannounced intervals;
- Limiting access to pads by support staff;
- Ensuring pads are properly secured at all times; and
- Having well-defined procedures for notifying authorities in the event a theft occurs.

Pharmacists must ensure that prescriptions are valid. They will need to familiarize themselves with various security features to ensure compliance with CMS and state Medicaid guidelines.

To prevent prescription fraud, health care professionals must educate themselves and employ appropriate technology.

notes

1. U.S. Drug Enforcement Administration fact sheet: Prescription drug abuse – a DEA focus. www.usdoj.gov/dea/concern/prescription_drug_fact_sheet.html, accessed May 28, 2008.
2. Centers for Medicare & Medicaid Services, www.cms.hhs.gov/center/intergovernmental.asp, accessed May 28, 2008.

e-mail us: Has your practice been the victim of prescription fraud? Tell us at connexion@mgma.com

mgma.com

From the home page, search for "tamper-resistant prescription pads"

PARTY LINE

Listening in on MGMA Member Community discussions

Handling high-risk OB patients

We're looking for a better way to track, review and determine who is a high-risk patient (e.g., gestational diabetic, placenta previa). I was wondering what other practices do and whether anyone has ever tried using a simple project management software for this?

— Trudi Noppenberger, practice administrator for Womens Health Center, Lebanon Ltd., Lebanon, Pa.

"We put a care alert in our EMR. When we access the patient, a care alert pops up to advise of any patient complication. The EMR L&D printout also references the high-risk and the reason, AMA , gestational diabetes, etc., so [staff members on] the floor will know if the patient needs to be triaged on L&D."

— Connie Libassi, practice manager for Physician Health Alliance, Scranton, Pa.

"Our nine physicians faced a similar concern about continuity of care, review of treatment plan and patient compliance. They elected, at the nurses' suggestion, to designate one nurse to assist and monitor patients "enrolled" in the high-risk clinic. None of our physicians are perinatalogists, so the level of "risk" is median, not truly high. The designated full-time nurse performs her duties as part of her regular duties, but necessarily spends more time on this area. Generally, the responsibilities are:

1. Act as main point of contact for "enrollees" for questions, counseling and telephone triage.
2. Accompany a physician during the high-risk clinic, every Tuesday morning with overflow to Monday morning, in the exam room and consulting office. All nine physicians rotate through the clinic.
3. Assist the physician in completing the chart note (electronic). Some physicians want the nurse to construct the note and then the physician reviews and signs. Other physicians construct their own.
4. Make sure assistant physician is adhering to the treatment plan.
5. Contact patients to check on compliance for testing and exams.

It works for our practice as we are seeing more of these types of patients."

— Richard Bevington, CMPE, practice manager for OB/GYN Specialists of Northern Kentucky, Edgewood, Ky.

"As a relatively small OB-GYN practice (three doctors, three certified nurse midwives), each of our RNs performs double duty as a case manager of a selected population such as high-risk OB, dysplasia, surgical. We assigned the high-risk OB to our primary triage nurse because many of the calls she receives are from this group. We keep the information on a fairly simple Excel file that is updated weekly and rests on a public drive that is accessible to our providers (with security). The high-risk group meets weekly to review the case and to manage the care. The triage nurse is responsible for this meeting. The Excel file also helps us to record outcomes so that we have a way to go back to track the scope of our high-risk OB problems and potentially the efficacy of our interventions. Sadly, we have not used this to the level I would hope regarding outcomes. Project management software is a very interesting idea — one I would also like to hear more about from my colleagues."

— Deborah Dworak, practice manager for Womens Care Center at Alice Peck Day Memorial Hospital, Lebanon, N.H.

"I have not seen a software product that tracks this. We rely on the doctor to let us know if the patient exceeds the normal allowable visits and then we go through and look to see if it is related to high-risk issues."

— Lynda Carnali, practice administrator for Advanced OB/GYN, Flemington, N.J.

"We only use modifier 22 when billing a high-risk delivery (59400 or 59510). When approved, we get a 20 percent differential. The criteria vary by plan. For visits in excess of 13, we bill E/M with modifier 25. Not every health plan reimburses them, but I would say it is 50/50. For example, United specifically has this on its national OB policy. 'Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.'"

— Dorimar Siverio-Minardi, MPH, MBA, LHRM, COBGCS, director of health plan payer relations for Womens Care Florida, Tampa.

mgma.com

Post your practice management questions to the MGMA Member Community (mgma.com/community) and we may feature them here.

How do you handle a sedated patient who wants to drive?

"Every now and then we have patients who claim to have rides home after local/sedation outpatient hand/wrist surgery but are planning to drive themselves. Has someone found an effective way to manage this situation?"

Tom Stackhouse, MD, MGMA member and medical director, Hand Surgery & Rehabilitation Center, Marlton, N.J, tstackhouse4@comcast.net, from the MGMA Ambulatory Surgery Center Assembly e-mail forum

Responses

"Ensure that patients check in with someone; do not go forward with the surgery until they have that person there. I had a procedure performed yesterday. I am a director at my hospital. Staff would not start until I called one of my nurses off the floor to assure the operating room staff that she'd get me home. She remained until my wife arrived. Until I had someone, I was stuck in limbo. Good practice."

"We approach the situation one of two ways:

- "Patient drives to the facility and admits planning to drive home. We remind them that should they have an accident, their insurance will most likely not cover them and that they could be held liable for driving under the influence (sedation). We offer to call a cab. If they insist on driving, we say we are obligated to contact the police. We document our conversation and notify the physician.
- "Patient drives him/herself to the facility but does not admit to planning to drive home. We tell patient we need the phone number of the responsible party who will be driving them so we can call when the patient is ready for discharge. If patient refuses to give us the number, we say we need to have the driver let us know when he/she arrives. We bring up the concern about driving 'under the influence' and possible lack of insurance coverage. If the patient leaves without being seen, we document all of the above and notify the physician."

"JUST SAY NO! (Including [to transport by] cabs and or buses.) Social services is always a good place to go — they can usually provide a driver to get the patient home, and they assume responsibility by signing the discharge orders. [Our] presurgery triage [staff] is adamant that patients cannot leave without a driver."

"We inform patients that they are putting themselves and others at risk, and then we call the local police."

"Our staff always informs patients that they will need a ride. We are in a tourist town and have a motel across the street with which we have worked out a discounted rate for patients. Someone escorts patients to their rooms; I have driven them to the motel with their vehicles. I have even made reservations for patients with their credit card for a room. I don't mind going an extra mile for some of the elderly who don't have anyone to help them out."

"Upon check-in, the patient's driver must sign our form indicating that they are the designated driver (the form includes post-op instructions). This policy is strictly adhered to — no exceptions. Patients don't make it beyond the front desk if they do not have this completed."

"We require the driver to sign paperwork acknowledging his/her agreement to escort the patient home. No driver, no procedure. We do not allow a patient to leave in a cab alone."

e-mail us: How do you deal with patients whose behavior could endanger themselves and/or the practice? Tell us at connexion@mgma.com

mgma.com

Visit our patient safety Practice Solutions Web page at mgma.com/patientsafety

The views expressed are those of the participants in MGMA's e-mail forums only and are not endorsed by MGMA. The views expressed do not constitute legal advice.

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MGMA e-Source, June 24, 2008

Incident reports: A positive part of an effective risk management program

By Kerri J. Gantt, CMM, LHRM, FACMPE, MGMA member and administrative director, Gastroenterology Associates of SW Florida PA, Fort Myers

Effective risk management programs in medical group practices depend on tools that identify hazards. They include:

- Incident reports
- Trending analyses
- Root-cause analyses
- Quality-improvement programs

Incident reports

Incident reports drive risk management programs. Changing your physicians' and staff's perceptions of incident reports and presenting them as a tool can enhance risk management activities and improve the overall delivery of care.

Incident reports describe the facts of any situation that deviates from usual and customary processes and/or outcomes. They should contain:

- Patients' names
- Diagnoses
- Dates and times of incidents
- Descriptions of the events
- A list of equipment used for procedures
- Physicians and staff involved in the incidents
- Witnesses' names

A risk manager, medical director and quality-improvement committee chair should review each incident report within 24 hours of an event.

Trend analysis

Evaluate all aspects of the data in the reports to identify trends. For instance, look for patterns by type of incident, processes involved and caretakers involved.

Root-cause analysis

A root-cause analysis entails reviewing each step of the event to determine why it proceeded in a certain manner. By doing this repeatedly, you can identify the source of the problem. Also attempt to identify other contributing factors.

Quality-improvement program

Develop a quality-improvement program to formally monitor and enhance processes and outcomes. Congruent with the overall mission of the practice, a plan should focus on high-risk, high-volume procedures.

Create a committee that includes personnel from all departments. This provides a broad view of practice systems. The committee must complete the studies and find ways to produce the desired outcomes.

Regularly update clinical staff about the program so that they learn about changes. This also stresses the importance of the risk management program. Emphasize that that even incidents employees perceive as trivial can illuminate larger problems. They should report all deviations from the norm.

Refrain from disciplining staff members involved in an incident. Instead, use the information from incident reports to improve systems or processes, not individual performance.

However, peer review is valuable. Encourage physicians to review each other's records to ensure quality care. Most important, after a thorough examination of incidents, physicians should determine where their peers deviated from the standard of care.

Format trend data so that they promote in-depth evaluation. Use histograms, line graphs, pie charts, scatter diagrams, flow charts, etc. Once the committee has evaluated a process and identified needed corrections, implement policy changes. Determine measurable outcomes and monitor the changes to determine if they lead to improvement.

As staff and physicians see the results of an effective risk-management program, their perception of incident reports will change, and they will be more likely to complete them. The quality-improvement committee will accumulate the data it needs to identify and improve troublesome areas and ensure that the practice provides quality health care.

Risk: What does it mean to you?

When we think about risk in practical terms, the words professional liability, identity theft, red flags, patient safety, harassment and HIPAA come to mind. The list seems to get longer each year, yet most of these issues fall under the umbrella term "corporate compliance."

The all-encompassing term can be daunting when you consider the need to address these risk-related issues, but creating a framework for dealing with these situations and legislation is an effective way to ensure that you are not blindsided.

From my perspective, the most important thing you can do to protect your group is to meet the rules and regulations of our industry. At our practice, the motto is: Find the problem, fix it and move on. To accomplish this, we set up a corporate compliance program about eight years ago and appointed a multidisciplinary team of 15 professionals to handle risk-management-related issues.

But don't let the numbers scare you. Corporate compliance programs are not only for large groups. You can tailor your program to fit your needs and enlist the help of your colleagues to ensure shared responsibility among stakeholders.

Our practice's corporate compliance team, which includes staff members from the human resources, finance, operations and legal departments, meets monthly to review and update our work plan with priorities for internal and external audits.

And these priorities change, depending on new legislation and a constantly shifting healthcare landscape. With the government Recovery Audit Contractor program, the ability to identify and report mistakes has become increasingly important. For a list of compliance items, visit mgma.com/compliance.

The corporate compliance team is also responsible for identifying areas of potential risk, including patient safety, legislation and employee issues. In our practice we have an employee hotline that allows staff members to raise concerns anonymously. Each issue is investigated and the findings are reported to the corporate compliance team and our group's legal counsel.

With the government Recovery Audit Contractor program, the ability to identify and report mistakes has become increasingly important.

Simply leafing through this issue of *MGMA Connexion* may jump-start conversations about risk management — and its many facets — in your practice. The quiz from ACMPE is sure to get those mental wheels turning, along with this issue's Practice Profile, which highlights patient informed consent. And there's the feature story about employee theft and embezzlement. Our goal is to ensure that managing risk is part of your team's repertoire.

In addition to reporting startling data, the MGMA questionnaire on theft and embezzlement sheds light on the importance of shared responsibility and effective checks and balances. If you do not have these types of systems in place — in which

see **Coach's Corner**, page 6

By Forrest D. Danner, FACMPE, MGMA Board chair, and vice president and chief operating officer, Aspirus Clinics Inc., Wausau, Wis., deand@aspirus.org

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- mgma.com/store: *Compliance Guide for the Medical Practice: How to Attain and Maintain a Compliant Medical Practice* (Item 6802)
- mgma.com/compliance

duties are shared by several staff members who can alert management to potential problems or holes in the process — you may end up inadvertently putting the fox in charge of guarding the henhouse.

We all know how easy it is to become complacent. We get accustomed to our routines and it becomes more difficult to be objective about issues. In other words, sometimes we need help to recognize that just because we've always done something one way it doesn't mean that it's the right way to do it.

By creating an effective corporate compliance program and appointing a compliance officer, practice professionals safeguard their group by establishing a process to identify risks and acting accordingly to prevent those risks from blossoming into serious problems.

I would like to take this opportunity to thank you for allowing me to serve as your Board chair for MGMA and to welcome Shena Scott as your new representative. Volunteering for this organization has been most rewarding for me, and I strongly urge you to become involved. Your talent is needed more than ever. This is an exciting time for all of us in healthcare, and it is rewarding to help shape the new terrain as an active member of this Association. I look forward to working with you in the coming year.

join the discussion: Tell us about your risk management strategy. What has worked for your practice? Give us the inside scoop at mgma.com/connexioncommunity or connexion@mgma.com.

What's your risk management IQ?

Test yourself with this 10-question quiz developed in accordance with the *Body of Knowledge for Medical Practice Management*. Published by ACMPE, the standard-setting and certification body of MGMA, the Body of Knowledge provides a framework for advancing your career, enhancing your skills and bettering your medical group practice.

The following questions are one part of a longer quiz on the MGMA Web site.

ACMPE Quiz: How much do you know about risk management?

1. What is the most frequently reported administrative ethical problem confronting healthcare organizations?
   A. Fraudulent credentials
   B. Conflict of interest
   C. Attendance reporting
   D. Resource allocation decisions

2. What does the term "statute of limitations" refer to in medical malpractice?
   A. The minimum amount of damages that can be assessed
   B. The time limit for legal action in a malpractice claim
   C. The maximum amount of damages that can be assessed
   D. The statutory limit on the amount an attorney may charge for representation

3. Which of the following is not a responsibility of a medical practice's risk manager?
   A. Determining if there are a proper number of handicap parking spaces available
   B. Setting liability insurance renewal rates
   C. Ensuring that all employees are familiar with building evacuation procedures
   D. Establishing an audit procedure to determine the timeliness of chart completion by providers

4. Which of the following is the best approach to reduce the risk of litigation for a group practice?
   A. Keeping signed consent forms on file
   B. Having a risk management department
   C. Employing only board-certified physicians
   D. Communication training for staff

5. Which of the following performance appraisal characteristics will increase the risk of legal challenge?
   A. A system with performance dimensions defined in behavioral terms
   B. A simple, numerical rating system
   C. A subjective trait-based rating system
   D. A system with an appeal mechanism

6. When does the Good Samaritan Statute impose liability on a physician?
   A. If the physician refuses to treat a patient
   B. If the physician comes to the aid of an injured person
   C. If the physician demonstrates gross negligence
   D. If the physician doesn't have a state medical license

7. What is a tort?
   A. A civil wrong
   B. A crime
   C. A breach of contract
   D. A banking violation

8. Which of the following should be incorporated into policies and procedures?
   A. Compliance with local, state and

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federal laws as they pertain to the operation of the practice.
B. An identical format that is consistent with the Joint Commission on Accreditation.
C. A process that provides for review every five years by practice leadership.
D. All situations that might arise in the practice.

9. Medical malpractice judgments against physicians are reported to which of the following agencies?
A. National Council of Alcoholism and Drug Dependence
B. Centers for Medicare & Medicaid Services
C. National Practitioner Data Bank
D. American Medical Association

10. Which organization promulgates corporate compliance program guidelines?
A. Congressional Legislation
B. The Office of the Inspector General
C. The Office of the U.S. Attorney General
D. Centers for Medicare & Medicaid Services

Answer Key:
1.B 2.B 3.B 4.D 5.C 6.C 7.A 8.A 9.C 10.B

Section 2: Managing Adverse Legal Events

- A little caution goes a long way: Five tips to help physicians avoid lawsuits. Shapiro SM, MD. *MGMA Connexion,* 2/2008
- Administrators can help physicians who are sued recover confidence. Vuletich M. *MGMA e-Source,* 2/2010
- Do your doctors have a reputation? Check the internet. Vuletich M. 6/2009
- Don't let litigation determine the legitimacy of your employment testing. Webster LA. MA, FACMPE, CPA. *MGMA e-Source,* 7/2009
- Don't underestimate the importance of thorough background checks on applicants. Vuletich M. *MGMA e-Source,* 8/2009
- Evaluating professional liability coverage options: What does a practice do when the professional liability insurance carrier decides to leave the market and not renew their coverage? Derise L, FACMPE, *ACMPE Professional Paper,* 10/2010
- How medical practices can respond positively to negative press. Pushkin J, APR. *MGMA In Practice Blog,* 8/2009
- Medical malpractice rates: Should you brace for shock or just increasing discomfort? Vuletich M. *MGMA e-Source,* 2/2010
- Risk tip: Informed refusal. Shepard S, MSN, MA, RN, CPHRM. *MGMA Connexion,* 10/2010
- Theft in group practices costs billions of dollars annually. McClure D, CPA, CFE, and Margolis J, MPA, FACMPE. *MGMA Connexion,* 9/2010
- Theft in the medical practice: Recognizing the risks and protecting your practice. Duncan LE, FACMPE. *ACMPE Professional Paper,* 8/2009

A little caution goes a long way

Five tips to help physicians avoid lawsuits

By Steven M. Shapiro, MD

about the author

Steven M. Shapiro, MD, chief medical officer, Best Practices Insurance Services LLC and Applied Medico-legal Solutions Risk Retention Group Inc., Phoenix, sshapiro@bpmp.com

Medical liability is an unpleasant fact of life for practicing physicians. But for you — the professional medical practice administrator working to reduce risk in the organization — it offers an opportunity to build a strategic partnership with your doctors.

An effective risk-reduction strategy must be simple and relatively inexpensive. These five tips can help keep down your practice's medical liability insurance premiums.

Tip 1: Have physicians give the personal touch

Coach your doctors to take extra steps to convey concern for the patient and his/her family. Misunderstandings that lead to lawsuits are often exacerbated by the perception that "the doctor didn't listen to me" or "the staff brushed me aside."

For example, remind physicians to sit down when speaking with patients and/or families. From the patient's perspective, the visit seems longer and more attentive; the patient believes that the physician did a better job.

Ensure that your staff members add to that personal touch with friendliness and concern. Make it a policy that patients are addressed by name and that employees know to stop their work, when possible, to answer questions. Make sure that staff answer all phone calls courteously and return messages expeditiously. These extra steps will make a significant difference in patients' perception of your practice.

Tip 2: Ensure that physicians obtain informed consent

Make certain your physicians get an informed consent when a patient refuses treatment. Such documentation is just as important as when someone agrees to receive care. For example, a patient with chest pain comes into the office but refuses a directive to go to the emergency room and then goes home and dies of a heart attack. The physician will almost certainly be sued.

If a patient refuses to follow recommendations for treatment — a decision that could jeopardize his/her health status — the physician should obtain a signed informed consent acknowledging that the patient understands the treatment recommendations and has decided not to follow them. Whenever possible, the physician should include the patient's family members in treatment discussions, particularly when the risks of refusal of care are severe. If the patient refuses, allow his/her family to be contacted and ensure that the physician documents this using guidelines of the Health Insurance Portability and Accountability Act (HIPAA).*

Patients who see their risks in writing will be less likely to refuse necessary care.

Tip 3: Apply office standards beyond office walls

Make sure that documentation standards follow your physicians when they visit patients in the hospital, where the environment can be chaotic. For example, physicians may dictate notes in the office, but may handwrite them in haste — perhaps illegibly — in the hospital. You need to take appropriate steps to ensure that physicians maintain the same high standard of documentation and communication in both settings.

Tip 4: Ensure documentation of other providers' care

Your practice's patients should understand what care they receive from your physicians vs. their other health care providers. For example, one of your internists may serve as a woman's primary care physician, but she

see **Group Practice Rx, page 26**

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- From the home page, search for "malpractice"
- In the *MGMA Store*, enter enter 6815 in the *Search Products* box for *The Medical Malpractice Survival Handbook*; 6672 for the Information Exchange "Liability Insurance Policies"; 6840 for the book *The Biggest Legal Mistakes a Physician Can Make and How to Avoid Them*

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may receive her breast exams and mammograms from a gynecologist in another practice. Ensure that your physician documents the care she receives from her gynecologist and have the patient initial those entries in the medical record.

Tip 5: Have physicians review results of all tests they order

One of the first rules of care a physician learns is, "Never order a test unless you personally check the results." Enforce this rule in your practice. Make sure physicians act on the results of tests, too — including tests ordered by consulting physicians. The primary care physician can still be liable for adverse outcomes resulting from delays in diagnosis when results from tests requested by another doctor are not acted on and communicated to the patient. It's imperative that you incorporate a tracking system to ensure appropriate care.

The same guidelines apply to referrals. Establish a protocol to verify that referrals are completed, consultants' recommendations reviewed and appropriate care continues.

The best way to win a lawsuit is to not get sued. You can assume the leadership role in your practice to establish — and adhere to — guidelines. Medical practice management professionals who follow these simple tips can help their physicians avoid these time-consuming, stressful and costly events.

Your practice's patients should understand what care they receive from your physicians vs. their other health care providers.

*To give informed consent, a patient must be competent and not impaired. HIPAA guidelines require such a patient to consent to contacting family members not present during the visit.

Defining Your Profession
MGMA e•Source
Information and inspiration for executives, straight from the source

MGMA e-Source, Feb. 23, 2010

Administrators can help physicians who are sued recover confidence

By Matthew Vuletich, MGMA senior writer/editor

Patients like confident doctors. A 2006 study published in *Mayo Clinic Proceedings* based on nearly 200 patient interviews confirmed that confidence was one of seven "ideal physician behaviors."

Ironically, when a patient or family members file a malpractice claim against a doctor – justifiably or not – the physician's confidence often disintegrates, according to the Physician Litigation Stress Resource Center. In "Coping with a medical malpractice suit," Sara C. Charles, Department of Psychiatry, University of Illinois School of Medicine, notes that "sued physicians often experience a 'see-saw effect': up one week and down another with alternating feelings of confidence and low self-esteem, of assurance and doubt."

The lonely physician

This lack of confidence can change physician behavior, asserts Lucien Roberts, MHA, FACMPE, MGMA member and executive director, Neuropsychological Service of Virginia, Richmond.

"It's very, very lonely for physicians when they get sued," Roberts says. "They often isolate themselves, even from their partners. Self-doubt creeps in, and they become suspicious of patients and begin to look at them differently. I don't know that that ever goes away for some doctors."

Some even find their careers unrewarding after being sued, Roberts asserts: "I saw a once confident, upbeat doctor become a good bit more cynical about most things in life after he was sued."

3 coping strategies

In her article, Charles cites three coping strategies to help doctors recover from the experience of being sued for professional liability:

1. **Seek social support**
   Physicians need to share their feelings and reactions with someone who is trustworthy, understanding and sensitive to their concerns, she says. Of course, sharing details of the case with anyone often contradicts the advice of legal counsel, but good legal advice isn't always sound psychological advice, she notes.

2. **Restore mastery**
   The malpractice experience deprives doctors of their sense of mastery. Activities that make them feel in control of their personal and professional lives, such as actively participating in their defense, can restore their sense of mastery.

3. **Change the meaning of the event**
   Malpractice charges imply that physicians are incompetent and, therefore, bad doctors, Charles says. So "it helps to recognize that litigation is about compensation, not competence, that those who are sued are often the best in their field," working with high-risk patients. Also, most physicians are eventually vindicated.

Supporting doctors

Roberts recommends a number of things practice administrators can do to help their doctors cope with the psychological effects of malpractice lawsuits:

- Work to get the suit dismissed as quickly as possible
- Provide moral support by accompanying physicians to depositions and court hearings
- Provide a few days off for a doctor without financial penalty to prepare for a hearing or court date
- Share any news about the case with a physician after hours so "the doctor can be a doctor during the day"

Another tip Roberts offers is to shield physicians from "painful reminders" of the suit in the future. For instance, when applying for reappointment with payers or credentialing with hospitals, doctors must "check that box" indicating whether they have ever been sued, settled a malpractice case or had a judgment against them. Instead of the provider checking the box and explaining the circumstances over and over again, the administrator should have the practice's attorney write a one-paragraph summary of what happened and submit that with future paperwork.

Ultimately, when administrators provide moral support for doctors who are sued, they "let physicians know that practice supports them," Roberts says. This helps physicians regain their confidence – and enjoy patient care again.

Defining Your Profession

MGMA e•Source
Information and inspiration for executives, straight from the source

MGMA e-Source, June 23, 2009

Do your doctors have a reputation? Check the Internet.

By Matthew Vuletich, MGMA senior writer/editor

Thanks to myriad healthcare Web sites, patients can access more information about physicians than ever before. While much of the information is mundane – where they received their education, for example – some of it can affect a practice's and provider's reputations.

Transparency laws

Some 22 states have transparency laws. Colorado became one of the latest to enact such legislation. The Michael Skolnik Transparency Act established a state-run online database that provides information on every doctor practicing in the state, including:

- Licensing information
- Board certification
- Hospital and health-care facility affiliation
- Disciplinary actions by a licensing agency, state or hospital
- Felony convictions
- Refusal of an insurance company to provide malpractice insurance
- Final judgments or settlements of malpractice or negligence lawsuits

Physician grades

Much of the same transparency information makes it into some of the myriad physician grading sites on the Internet. For example, HealthGrades.com combines this information with responses to patient questionnaires to issue a report for each of the 750,000 doctors on its site, says Scott Shapiro, HealthGrades spokesperson.

"We feel it's important to have both sets of information available – objective and subjective," Shapiro says.

HealthGrades then divides providers into three tiers:

- Five-star doctors are board-certified, have no history of disciplinary actions or malpractice judgments and are affiliated with a five-star hospital
- Recognized doctors meet all the five-star conditions except they are not affiliated with a five-star hospital
- Others do not meet one or more of the conditions

Doctor reviews

Unlike HealthGrades, Angie's List allows patients to post reviews about physicians on its site, as do dozens of other sites. Angie's List Communications Director Cheryl Reed admits these reviews make some doctors wary.

"While there is some angst about negative reports, the majority of reports on Angie's list are from members who are happy with the care they receive," she says.

Patient reviews have caught the attention of Medical Justice, a company founded by Jeffrey Segal, MD, a neurosurgeon. Segal says Medical Justice provides a "patented, pre-emptive strategy to deter meritless lawsuits," but it also has taken on the issue of online physician reviews. Segal asserts that many reviews amount to defamation and a physician cannot respond because of state and federal privacy laws.

While Reed says Angie's List does not allow anonymous posts, posters' names do not appear with their report; they're available upon request to Angie's List members. She says the company works with doctors and patients to resolve disputes.

Medical Justice does not oppose online patient reviews in principle, but calls for greater transparency and context around them, Segal says. Until that happens, the company offers members "mutual privacy agreements" – contracts in which patients agree not to post online accounts of their experiences with doctors. Segal says the contracts allow patients to complain to other doctors, licensing boards, attorneys and courts.

All of this leads Shapiro to offer a bit of advice: "Doctors should Google themselves and follow the links patients are following, and they need to understand what online is in their control and what's not."

Defining Your Profession

MGMA e•Source
Information and inspiration for executives, straight from the source

MGMA e-Source, July 14, 2009

Don't let litigation determine the legitimacy of your employment testing

By Lee Ann H. Webster, MA, FACMPE, CPA, MGMA member and practice administrator, Pathology Associates of Alabama PC, Birmingham

Employers, afraid of lawsuits by former employees, frequently provide minimal information in response to reference checks. While the applicant's former employer may fear litigation from discussing his/her employment history with you, your practice risks a lawsuit for negligent hiring if it fails to perform sufficient and reasonable employment checks.

Practice executives should know that reference checks could result in litigation. A 2000 study of federal court cases dating from 1978 compared adverse-impact litigation cases for reference checks, background investigations, medical/physical examinations, drug tests and polygraph tests, and found that background investigations and reference checks presented the highest risks of legal repercussions. These tests were more likely to result in lawsuits and more likely to go against the employer. This study concluded that drug testing presented a low risk of legal consequences.[1] Other research indicates that tests generally have no adverse impact on any protected group and seldom result in adverse-impact litigation.[2]

While online searches are for the most part legal, employers should ensure that they don't misuse these resources. Because such searches are relatively new, they have not been thoroughly tested in the courts.[3] Employers who use Internet testing in a manner that adversely affects members of protected groups could face legal action.[4]

Most adverse-impact cases are brought against large companies. However, all employers can reduce the potential for legal woes by ensuring that employment tests:

- Are appropriate for the position
- Are given and interpreted consistently for all applicants for similar positions
- Accommodate the known disabilities of applicants

You can reduce your risk of being second-guessed on the adverse-impact front by ensuring that employment tests are job-related and consistent with business needs. Are credit reports really necessary in screening applicants for positions without financial responsibilities, such as nurses? Is a high school diploma essential for a file clerk or receptionist?

The Equal Employment Opportunity Commission takes the position that having a blanket "no felons" policy adversely affects certain minority groups, and the employers may only consider conviction records relevant to the position.[5] In determining relevancy, consider:

- Whether the employee would have extensive contact with the public
- His/her financial responsibilities
- His/her access to confidential information, drugs, controlled substances, keys or other means of obtaining resources[6]

The road to a good hire is paved with legal landmines. Education and competent legal advice, combined with a careful analysis of your practice's situation, can help you minimize risks and hire better employees.

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Defining Your Profession

MGMA e•Source
Information and inspiration for executives, straight from the source

MGMA e-Source, Aug. 11, 2009

Don't underestimate the importance of thorough background checks on applicants

By Matthew Vuletich, MGMA senior writer/editor

A scrub tech in Colorado pleaded not guilty last week to stealing syringes with pain medication, injecting herself and then refilling the syringes with saline, which were then used on patients. As of July 11, 21 people had been infected with hepatitis C by the employee and as many as 5,000 could have been exposed at two facilities where she worked at different times. Before moving to Colorado, she reportedly worked at healthcare facilities in New York and Texas and was fired from the New York job for "poor performance."

Another Colorado case involved a nurse who was arrested last month – and allegedly fired from a hospital – for stealing medication. More than a year before, a different Denver hospital had reportedly fired her for misconduct and had classified her as ineligible for rehire.

What does this mean for medical group practice administrators and other professionals? They cannot underestimate the importance of an exhaustive screening process for all potential staff members, including reference checks and comprehensive background checks, says Kenneth T. Hertz, CMPE, a principal with the Medical Group Management Association Health Care Consulting Group.

"For a minimal fee, you can get pretty comprehensive background checks from various companies," Hertz says. Some of them can be found through the National Association of Professional Background Screeners.

Administrators who chose to conduct their own checks should consult the federal Fair Credit Reporting Act (FCRA), which sets national standards for employment screening, says the Privacy Rights Clearinghouse. Certain aspects of the FCRA do not apply to practices that conduct their own background checks, the clearinghouse notes, and some state laws impose additional or more stringent restrictions than the FRCA.

Generally, the pieces of information that might appear in a background check are:

- Driving records
- Vehicle registration
- Credit reports
- Criminal records
- Court records
- Neighbor interviews
- Bankruptcy records
- State licensing records

Practices must obtain permission from an applicant to access education, military and medical records, the clearinghouse notes.

Reference checks can be a little trickier for a couple of reasons, Hertz says. Most applicants will not knowingly include a reference source that will provide a negative review, and many sources are reluctant to divulge much information about a past or present employee for fear of a lawsuit.

The Privacy Right Clearinghouse says "a former boss can say anything [truthful] about your performance. However, most employers have a policy to only confirm dates of employment, final salary and other limited information." Hertz recommends conducting behavioral reference checks. For example, ask how an applicant might respond when faced with a certain hypothetical situation at work.

When it comes down to it, hiring the right employee is a matter of practice liability and patient safety. The question isn't whether a practice afford to conduct a thorough background check. It's whether a practice can afford not to?

American College of Medical Practice Executives
ACMPE®

ACMPE Paper, October 2010

Evaluating Professional Liability Coverage Options: What does a practice do when the professional liability insurance carrier decides to leave the market and not renew their coverage?

By: Louise Derise, FACMPE

This professional paper manuscript is submitted in partial fulfillment of the requirements for election to Fellow status in the American College of Medical Practice Executives

This manuscript was prepared as part of meeting various recognition criteria as set forth and may be changed from time to time by the American College of the Medical Practice Executives (ACMPE). The experiences, thought, ideas and opinions set forth are solely those of the author.

They do not reflect any position on the part of ACMPE with respect to their completeness, correctness or accuracy of the paper's contents, for example, on points of law or accountancy in effect at the time of or subsequent to the date of paper completion.

A multi-specialty practice including Podiatry, Orthopedics, Family Practice, Internal Medicine, Obstetrics and Gynecology, Pediatrics and General Surgery consisting of 20 physicians were notified by their existing professional liability insurance carrier that they would not be renewing their coverage for the coming year. The practice's existing carrier decided to leave the medical malpractice market in their state. This forced the practice to assess their current professional liability insurance coverage and evaluate their options. The practice is located in the state of Louisiana where there is legislation enacted that has set a medical malpractice cap amount of $500,000 for each claim. A state agency was created to manage this process and this agency is the Louisiana Patient Compensation Fund. In order to participate in this state fund, each physician is required to pay a premium each year based on their specialty rating. The physicians of the practice chose to continue to participate in this fund; therefore, the medical malpractice cap amount will remain in place and the fund will cover them for the final $400,000 should any judgment be ruled against them. With that being said, each physician is responsible for legal expenses, defense costs and the first $100,000 if a judgment results. The practice's existing professional liability insurance carrier provided coverage for what the state fund will not cover.

With their current carrier deciding to leave the market, the physicians were required to evaluate their options. The physicians could have decided to purchase insurance coverage from another carrier, develop a self-insurance fund to share the risk of these expenses or be personally responsible for the legal expenses, defense costs and the first $100,000 of a judgment.

The Administrator met with the practice's legal counsel and insurance agent to

explore options before presenting any information to the Board of Directors. One of the possible alternatives was to obtain coverage from another professional liability insurance carrier to replace their existing coverage. An advantage to continuing to purchase this type of coverage for the practice would be to maintain a regular premium amount for each physician based on their specialty for each year. In this setting, the practice would pay a set premium for each physician each year and the insurance carrier would be responsible for all legal expenses and defense costs incurred and the first $100,000 if a judgment results. This would provide peace of mind to the physicians knowing they are covered for any potential medical malpractice claims. On the other hand, the physicians would be paying annual premiums with the possibility of a medical malpractice claim never being filed. Also, there is a possibility of having to purchase tail coverage or prior acts coverage when changing from one insurance carrier to another. Finally, annual premiums paid to insurance carriers usually increase each year even though there are no outstanding claims or activity.

Another possible alternative was for the physicians to remain a participant in the state fund to have the legislative malpractice award cap in place and not purchase any insurance coverage for the amounts that the state fund would not cover. This would in essence have each physician personally liable for all legal expenses, defense costs and the first $100,000 if a judgment would result against them from a claim. By selecting this option, the physicians would have to transfer from a “claims-made” status to an “occurrence” status. “Claims-made” status covers the physician when the claim is made if the occurrence was also during the covered period. “Occurrence” status covers the physician if coverage is in place when the claim occurs, regardless of when the claim is

made. This would cause a change in premium amount to participate in the state fund. Occurrence premiums are higher than claims-made premiums. Some physicians in the practice were willing to accept this risk to save the large annual premiums and others were not.

A third alternative was to remain a participant in the state fund to have the legislative malpractice award cap in place and to develop a separate self insurance program to cover all the legal expenses, defense costs and judgment amounts that the state fund would not cover. The physicians would continue to pay their surcharge premium to the state fund as well as pay an additional premium to the self insurance program. This additional amount would only be paid to fund the program based on the claims activity in the program. By instituting this program, it would allow several physicians to share the risk each year as well as to share in the financial responsibilities to cover the legal fees, defense costs and judgment amounts. It would also make the physicians more cognizant of the activity surrounding a medical malpractice claim because they would manage the program and be responsible for decisions regarding these medical malpractice claims. A disadvantage to the program would be that the funding amounts would vary each year depending upon the claims activity. Also, a physician may pay money into the program and have that money allocated to a claim to which he or she may not be named. This option would not be beneficial to a practice that has only a few physicians as there may not be enough of them to share the risk and expenses. By selecting this option, the physicians in the practice would have to transfer from a "claims-made" status to an "occurrence" status.

The evaluation process included the Administrator, the practice's legal counsel,

the practice's insurance agent, the practice's outside CPA firm, the Board of Directors and all the physicians of the practice. The process began with the Administrator and the insurance agent gathering data necessary to evaluate each alternative thoroughly. The insurance agent gathered past claims history on all of the physicians of the practice which included all legal fees paid, defense costs and any judgments paid. The practice's legal counsel and outside CPA firm used their knowledge of other clients and reviewed files to better prepare them to be able to present the various alternatives. The Administrator of the practice consulted with other practices, attended seminars and conferences on professional liability to explore options and ways other entities may have addressed this issue. The team met to evaluate the information they had gathered and prepared presentations of the alternatives and the pros and cons of each alternative to the Board of Directors for their input and approval. After discussing each alternative in great detail, the Board of Directors agreed on the third alternative which was to remain a participant in the state fund to have the legislative malpractice award cap in place and to develop a separate self insurance program to cover all the legal expenses, defense costs and judgment amounts that the state fund would not cover. The Board of Directors agreed that an issue of this magnitude should be presented to all the physicians of the practice to obtain their approval and acceptance. The physicians agreed that the third alternative was the best solution for the practice because after reviewing the case history of all the physicians, it was determined that $2,000,000 was paid in premiums over several years and only $300,000 was paid in legal expenses, defense costs and judgment amounts during the same timeframe. They also agreed that having 20 physicians was a sufficient number of physicians to successfully manage a self insurance program and that the risk of

implementing this program would not be detrimental to an individual physician.

Once the physicians agreed on a course of action, the implementation process began. The first step toward implementing the solution was for the Administrator and their legal counsel to draft a legal document to create the professional liability self insurance program. This legal document covered all of the aspects of the program from who will be covered to how the funding would be assessed. This document had to address all of the Louisiana state regulations and that the program was intended to replace commercial medical professional liability insurance only. Also, the document stated that all legal expenses, defense costs and any judgment amounts not covered by the state fund would be covered by the self insurance program.

All of the costs associated with the program were to be allocated based on the physician's proportionate share for each policy year. The calculation method used to determine a physician's proportionate share amount is the percentage of the physician's Louisiana Patient Compensation Fund surcharge amount to the total of all the physicians' Louisiana Patient Compensation Fund surcharge amounts for each policy year. The document included language that would allow the Board of Directors to charge each physician named in a claim an amount in addition to his or her proportionate share as follows:

1. an additional 10% of the total costs for the physician's first claim or lawsuit filed in the same policy year
2. an additional 20% of the total costs for the physician's second claim or lawsuit filed in the same policy year
3. an additional 50% of the total costs for each of the three or more claim(s) or

lawsuit(s) filed naming the physician in the same policy year.

This language was agreed upon by the physicians to hold those accountable who were named in claims or suits and to provide some financial benefits for those physicians that were not named. The document addressed that the funding payments were to be retained in the program for at least 4 years or once all of the claims for that policy year were closed before any refunds could be issued or monies transferred to future policy years. This document was drafted as an amendment to each physician's employment agreement with the practice and the terms of the self insurance program followed the terms of the employment agreement. This document also provided for the Board of Directors to make all decisions regarding the defense of a claim, including the choice of legal counsel, decisions regarding litigation strategy, whether a case will be defended or settled and the timing of these decisions. Finally, each physician is required to cooperate in all matters relating to the defense of all claims or lawsuits even beyond the term of their employment agreement.

Once the legal document was prepared, the practice's outside CPA firm reviewed it and the cost allocation process to make sure the program remained in compliance with Generally Accepted Accounting Principles and the IRS codes and regulations. It was determined by the practice's outside CPA firm that the funding amounts were not a tax deductible expense and that only the expenses paid by the program were tax deductible. It was recommended and decided that a separate checking account be opened to keep the funds separate from regular business matters of the practice. Separate invoices were issued to the program for any legal expenses or defense costs associated with the program. A separate accounting system was developed to manage the claims associated

with the different policy years as well as each physician's activity. This system was created by the Administrator and managed in Excel. A sample of this system is located in Appendix A. It was determined that $150,000 would be an adequate amount to initiate the program and cover the costs of start-up and maintenance of the program for a few years. Each physician participating in the program would receive a quarterly statement documenting the progress of the program. At the close of each year, funding payments for the coming year are calculated by the Administrator and legal counsel based on the activity in the program.

The legal document and accounting system were presented to the physicians for their final acceptance and approval. Each physician was required to execute the legal document agreeing to adhere to the terms of the program and it became an amendment to their employment agreement. The program was started in December, 2002, and is still operating today. The entire decision making process took approximately nine months as the physicians were given a year's notice of termination by the practice's professional liability insurance carrier which gave the practice plenty of time to evaluate their options and investigate them fully.

The physicians had to alter their understanding of their professional liability coverage and budget accordingly to fund the program each year. Since there was no longer a third party insurance carrier, the Administrator was more actively involved in managing the professional liability claims and worked directly with the practice's legal counsel on each claim. The Board of Directors also took a more active role as it is the final decision maker as to how to proceed with each claim. One issue that may have caused the physicians to select another alternative was that several of the physicians

began performing high risk procedures after the inception of the self insurance program. Those procedures resulted in an unusually high number of claims that the practice had not anticipated. This in part was due to the nature of the difficulty of these procedures and the huge responsibility placed on the patient to change their lifestyle in order to have a successful outcome. These procedures were also new to the insurance industry; therefore, strict guidelines were not in place to limit the exposure by assuring that patients were thoroughly screened. Several of the physicians in other practice groups were concerned about the risk they had assumed in the program for these high risk claims and possibly other claims of this nature in the future.

Another issue that arose after a few years of the program being in place was the fact of some physicians who had exited the practice for various reasons were avoiding and resisting their contractual obligation to continue contributing into the professional liability self insurance program. The document executed by the physicians does allow for the practice to take legal action to obtain the contractually required funding after a physician leaves the practice. Fortunately, those physicians did not have a large negative balance in the fund and at this point it is not worth pursuing legal action to recover those funds.

The selected alternative did produce the outcome expected with the exception of the claims resulting from the high risk procedures and the issue surrounding the exited physicians not honoring their contractual obligation to continue to fund the program. The physicians' funding payments were much lower than the estimated premiums submitted by the professional liability insurance carriers for continued coverage. It also encouraged the physicians to be more alert to potential risk management issues. With the Board of

Directors and the Administrator taking a more active role in the professional liability risk management area of the practice, the practice has been able to provide better support and education to reduce any exposure.

Looking back, the investigation process would have remained the same and the Administrator believes the result would have been the same because the program is still in place today. Over the last couple of years, the practice has obtained quotes for coverage from professional liability carriers. The premiums quoted have been drastically higher than the funding payments made by the physicians and this continues to support that the practice made the right decision. The activity in the program has decreased as the Bariatric claims come to an end due to the passage of time, which further supports that this was the best decision for the practice.

Professional Liability Self Insurance Program
Policy Year 12/01/02 to 11/30/03
Report as of

PHYSICIAN	12/1/02 to 11/30/03 Proportionate Share %	Amount of Proportionate Shared Funded	M.G. case (DOL 12/02 to 01/04)	G. R. case (DOL 12-23-02)	G. B. case (DOL 5-6 to 5-9-03)	12/01/02 to 11/30/03 Balance
FAMILY PRACTICE:						
Dr. A	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
Dr. B	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
Dr. C	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
Dr. D	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
Dr.E	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
INTERNAL MEDICINE:						
Dr. F	2.14%	$ 2,533.41	$ (89.23)	$ (315.60)	$ (42.78)	$ 2,085.80
Dr. G	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (264.68)	$ 2,128.49
PEDIATRICS:						
Dr. H	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
Dr. I	2.14%	$ 2,533.41	$ (89.23)	$ (51.02)	$ (42.78)	$ 2,350.38
OB/GYN:						
Dr. J	12.91%	$ 9,683.85	$ (537.75)	$ (307.46)	$ (257.85)	$ 8,580.78
Dr. K	12.91%	$ 9,683.35	$ (537.75)	$ (307.46)	$ (257.85)	$ 8,580.28
Dr. L	4.59%	$ 5,116.78	$ (191.05)	$ (109.24)	$ (91.61)	$ 4,724.88
Dr. M	12.91%	$ 9,638.85	$ (537.75)	$ (307.46)	$ (257.85)	$ 8,535.78
SURGERY:						
Dr. N	8.40%	$ 8,456.58	$ (350.01)	$ (200.12)	$ (167.83)	$ 7,738.62
Dr. O	8.40%	$ 8,456.58	$ (350.01)	$ (200.12)	$ (167.83)	$ 7,738.62
ORTHOPEDICS:						
Dr. P	8.40%	$ 8,456.58	$ (350.01)	$ (200.12)	$ (167.83)	$ 7,738.62
Dr. Q	8.40%	$ 8,456.58	$ (812.77)	$ (200.12)	$ (167.83)	$ 7,275.86
PODIATRY:						
Dr. R	3.78%	$ 4,469.19	$ (157.41)	$ (90.00)	$ (75.48)	$ 4,146.31
TOTAL	100.00%	$ 95,219.03	$ (4,627.58)	$ (2,645.84)	$ (2,218.91)	$ 85,726.70

PROFESSIONAL LIABILITY
SELF INSURANCE PROGRAM **Case: G R vs Dr. F**
Report as of **Date of Loss: 12/23/03**

PHYSICIAN	12/01/02 TO 11/30/03 PROPORTIONATE SHARE PERCENTAGE	July Invoice	08/27/04 Invoice	10/11/04 Invoice	11/11/04 Invoice	Total Allocation for G R Case
FAMILY PRACTICE:						
Dr. A	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
Dr. B	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
Dr. C	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
Dr. D	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
Dr.E	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
INTERNAL MEDICINE:						
Dr. F (add'l 10% for 1st case)	2.14%	-$142.46	-$110.34	-$20.01	-$42.79	-$315.60
Dr. G	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
PEDIATRICS:						
Dr. H	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
Dr. I	2.14%	-$23.03	-$17.84	-$3.24	-$6.92	-$51.02
OB/GYN:						
Dr. J	12.91%	-$138.78	-$107.50	-$19.50	-$41.68	-$307.46
Dr. K	12.91%	-$138.78	-$107.50	-$19.50	-$41.68	-$307.46
Dr. L	4.59%	-$49.31	-$38.19	-$6.93	-$14.81	-$109.24
Dr. M	12.91%	-$138.78	-$107.50	-$19.50	-$41.68	-$307.46
SURGERY:						
Dr. N	8.40%	-$90.33	-$69.97	-$12.69	-$27.13	-$200.12
Dr. O	8.40%	-$90.33	-$69.97	-$12.69	-$27.13	-$200.12
ORTHOPEDICS:						
Dr. P	8.40%	-$90.33	-$69.97	-$12.69	-$27.13	-$200.12
Dr. Q	8.40%	-$90.33	-$69.97	-$12.69	-$27.13	-$200.12
PODIATRY:						
Dr. R	3.78%	-$40.62	-$31.47	-$5.71	-$12.20	-$90.00
TOTAL	100.00%	-$1,194.29	-$925.07	-$167.78	-$358.70	-$2,645.84

PROFESSIONAL LIABILITY
SELF INSURANCE PROGRAM **Case: G B vs Dr. G**
Report as of **Date of Loss: 5/6 to 5/9/03**

PHYSICIAN	12/01/02 TO 11/30/03 PROPORTIONATE SHARE PERCENTAGE	08/13/04 Invoice	09/15/04 Invoice	10/11/04 Invoice	11/11/04 Invoice	12/10/04 Invoice	Total Allocation for G B Case
FAMILY PRACTICE:							
Dr. A	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr. B	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr. C	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr. D	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr.E	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
INTERNAL MEDICINE:							
Dr. F	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr. G (add'l 10% first case)	2.14%	-$87.71	-$94.47	-$44.03	-$20.87	-$17.59	-$264.68
PEDIATRICS:							
Dr. H	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
Dr. I	2.14%	-$14.18	-$15.27	-$7.12	-$3.37	-$2.84	-$42.78
OB/GYN:							
Dr. J	12.91%	-$85.45	-$92.03	-$42.89	-$20.34	-$17.14	-$257.85
Dr. K	12.91%	-$85.45	-$92.03	-$42.89	-$20.34	-$17.14	-$257.85
Dr. L	4.59%	-$30.36	-$32.70	-$15.24	-$7.23	-$6.09	-$91.61
Dr. M	12.91%	-$85.45	-$92.03	-$42.89	-$20.34	-$17.14	-$257.85
SURGERY:							
Dr. N	8.40%	-$55.62	-$59.90	-$27.92	-$13.24	-$11.16	-$167.83
Dr. O	8.40%	-$55.62	-$59.90	-$27.92	-$13.24	-$11.16	-$167.83
ORTHOPEDICS:							
Dr. P	8.40%	-$55.62	-$59.90	-$27.92	-$13.24	-$11.16	-$167.83
Dr. Q	8.40%	-$55.62	-$59.90	-$27.92	-$13.24	-$11.16	-$167.83
PODIATRY:							
Dr. R	3.78%	-$25.01	-$26.94	-$12.55	-$5.95	-$5.02	-$75.48
TOTAL	100.00%	-$735.32	-$791.99	-$369.10	-$175.00	-$147.50	-$2,218.91
Total per invoice		$735.32	$791.99	$369.10	$175.00	$147.50	$2,218.91
Difference		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

PROFESSIONAL LIABILITY
SELF INSURANCE PROGRAM **Case: M G vs Dr. Q**
Report as of **Date of Loss: 12/2002 to 01/2004**

PHYSICIAN	12/01/02 TO 11/30/03 PROPORTIONATE SHARE PERCENTAGE	10/11/05 (1st) Invoice	10/11/05 (2nd) Invoice	11/09/05 Invoice	12/14/05 Invoice	Total Allocation for M G Case
FAMILY PRACTICE:						
Dr. A	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr. B	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr. C	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr. D	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr.E	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
INTERNAL MEDICINE:						
Dr. F	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr. G	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
PEDIATRICS:						
Dr. H	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
Dr. I	2.14%	-$42.22	-$37.60	-$6.60	-$2.80	-$89.23
OB/GYN:						
Dr. J	12.91%	-$254.43	-$226.62	-$39.79	-$16.90	-$537.75
Dr. K	12.91%	-$254.43	-$226.62	-$39.79	-$16.90	-$537.75
Dr. L	4.59%	-$90.40	-$80.51	-$14.14	-$6.01	-$191.05
Dr. M	12.91%	-$254.43	-$226.62	-$39.79	-$16.90	-$537.75
SURGERY:						
Dr. N	8.40%	-$165.61	-$147.50	-$25.90	-$11.00	-$350.01
Dr. O	8.40%	-$165.61	-$147.50	-$25.90	-$11.00	-$350.01
ORTHOPEDICS:						
Dr. P	8.40%	-$165.61	-$147.50	-$25.90	-$11.00	-$350.01
Dr. Q (add'l 10% first case)	8.40%	-$384.56	-$342.52	-$60.15	-$25.55	-$812.77
PODIATRY:						
Dr. R	3.78%	-$74.48	-$66.34	-$11.65	-$4.95	-$157.41
TOTAL	100.00%	-$2,189.51	-$1,950.17	-$342.45	-$145.45	-$4,627.58
Total per invoice		$2,189.51	$1,950.17	$342.45	$145.45	$4,627.58
Difference		$0.00	$0.00	$0.00	$0.00	$0.00

How medical practices can respond positively to negative press

Tuesday, Aug 25, 2009

Guest blog by Jon Pushkin, APR president of Pushkin Public Relations, Denver, Colo.

Photo by Gisela Giardino

"It takes 20 years to build a reputation and five minutes to ruin it." Warren Buffet was right. Denver's Rose Medical Center, which has long enjoyed a stellar reputation as one of Denver's premier hospitals, is learning that lesson the hard way.

Rose's reputation was badly damaged when the public learned that a drug-addicted surgical scrub tech with hepatitis C had potentially exposed thousands of patients to the disease. For six months, she stole syringes with pain medication, injected herself, refilled the syringes with saline and returned them for use on patients. It was bad enough for the hospital to deal with outrage over how this happened and why it took so long to discover the problem. Now Rose faces dozens of lawsuits and a daily stream of negative news stories.

Don't panic

Unfortunately, when faced with a crisis or negative press, the first instinct of many medical practice leaders is to hide and hope it goes away. Others get defensive. Some request retractions or go to war with a publication. Obviously, none of these responses is very smart. You can't hide and you can rarely intimidate the media into a retraction. What you *can* do is take your medicine and address the problem. Better still, you can plan ahead so if you find yourself in hot water you won't get burned.

A good crisis communications plan anticipates potential problems and develops a response for each scenario. It designates roles and responsibilities for each member of the crisis team, identifies a primary spokesperson and establishes a command center where accurate information can be managed and delivered at specified times through specific channels, such as your Web site, Twitter or a media briefing.

Follow the CAP formula

- **Compassion**
  The most important part of your response is to show compassion to the public. For example, "Our top priority is the safety of our patients and staff. We've established a 24-hour hotline where patients and family members can get information and we've arranged counseling for our employees." Provide accurate, honest information as quickly as possible. Explain what you know so far by sticking to the facts. Never speculate. Speak with one consistent voice.
- **Action**
  Explain what you are doing to fix the problem and make sure that it does not happen again. For example, "We are reviewing all our safety and hiring procedures to make sure that our security and screening processes are the best they can be."
- **Perspective**
  Use your history to your advantage, for example, "We've been a part of this community for 50 years. Nothing like this has ever happened and we are doing everything we can to make sure this is an isolated incident and that it never happens again."

Of course, bad press doesn't come only from a disaster. It can result from an unhappy employee, an angry patient suing for malpractice, a bad business deal, a crossed ethical boundary, or something as simple as a bruised ego or poor customer service.

That's why it's vital to establish and maintain good relationships with local media and your patients. It can help you mitigate the damage from a negative story by making it more likely that the reporter and the public will give you the benefit of the doubt. Once you get that opportunity, don't waste it. Make sure you:

- Communicate openly, honestly, factually and compassionately.
- Keep your cool. Don't get baited into a confrontation.
- Ask the reporter for an opportunity to convey your point of view. Don't demand a retraction; instead, ask for a meeting to tell your side of the story.
- Avoid saying "no comment." It sounds like you have something to hide. If you don't know the answer, tell them you will find out and get back to them. If your lawyer recommends not answering, then find a way to respond without giving your lawyer a heart attack.

- Create three key messages and stick to them as much as possible. "We are devastated that this happened." "We are doing everything we can to fix the problem." "This is an isolated incident and we are doing everything in our power to make sure it will never happen again." Stay on message. Express your key points and repeat them as often as you can without sounding like a robot.

The first step to managing negative press for your medical practice is to plan ahead. If you don't have a crisis communications plan now, get one. Gather your team, brainstorm every possible scenario, assign roles and responsibilities and create a sample response to every crisis using the CAP formula.

The reputation you've worked so hard to build can be damaged in the blink of an eye. If you wait until a disaster occurs to start thinking about damage control, it could be too late.

Defining Your Profession
MGMA e•Source
Information and inspiration for executives, straight from the source

MGMA e-Source, Feb. 23, 2010

Medical malpractice rates: Should you brace for shock or just increasing discomfort?

By Matthew Vuletich, MGMA senior writer/editor

After roughly six years of major increases in the cost of professional liability insurance, the market seemed to calm a bit in 2007 and 2008, according to the *MGMA Cost Survey for Single-Specialty Practices: 2009 Report Based on 2008 Data*.

For instance, three specialties – anesthesiology, cardiology and orthopedic surgery – experienced decreases in malpractice insurance rates in 2008. General surgery, pediatrics, OB/GYN and family practice experienced only modest increases, but some of these followed decreases in previous years.

"Enjoy it because it's going to turn," warns Thomas Cox, ARM, MGMA member and president, Bluewater Solutions LLC, Richmond, Va. However, "when it turns, it won't be a sudden crack, like when the market spiked from 2000 to 2006. It's a very weird time. It looks a lot like 1997 through 1999, the years before the last hard market."

To know why Cox thinks malpractice insurance premiums will climb again soon, you need to know what happened in the 1990s. After the hard market of 1985-86, which saw underwriting and a spike in premiums, many companies left rates high well into the '90s. This resulted in growth of company surpluses, he says. Then many companies began to cross state lines to spread risk and reduce market volatility. Cox says this competition for market share prompted many insurance companies to offer coverage at unsustainable rates.

As loss severity and frequency mounted in the late '90s, carriers realized they had collected insufficient premiums (Jury Verdict Research notes that the average malpractice jury reward doubled from about $500,000 to more than $1 million between 1996 and 2001). Furthermore, in 2001 or 2002, when carriers faced the task of having to cover increased losses, a recession reduced their investment income, Cox explains.

"Carriers got caught behind the curve," Cox explains. "They assumed that the lost severity rates would continue to rise, so they had to increase rates to make up for the losses." Hence the triple-digit increases many medical practices experienced from 2000 to 2008, according to MGMA data.

Turning toward the present, Cox says we've had an unusually long soft market because of the financial crisis and lingering woes in the credit market. Plaintiffs' attorneys working on a contingency-fee basis depend on lines of credit to pay expenses and fees when a claim is active.

Banks are still not loaning much money, so plaintiffs' attorneys cannot access credit as easily and are taking fewer cases, he says. Once the credit market improves, increases in malpractice cases will probably rise.

Ominously, Cox says, a number of carriers have begun to drop their rates to unsustainable levels again to capture greater market share – a trend he's observed mainly in the Southeast. "This makes it hard for all insurance companies to keep rates where they should be based on history," he notes.

Another potential omen is that some tort reform laws passed recently by states to help stabilize malpractice insurance face significant legal challenges. The Illinois Supreme Court, for example, recently struck down tort reform laws as unconstitutional, Cox said.

"What happens is people start asking why physicians should be given protection from lawsuits that accountants, architects and other professionals are not given," he says. Also, caps on damages are seen as unconstitutional by some because they unfairly limit the ability of the very old, the very young and stay-at-home parents (those who have little or no "economic" losses) to get legal representation. Without the potential of a big payout, few plaintiffs' attorneys will accept these cases.

While stable right now, a combination of events could spark a new round of increases in medical malpractice insurance costs, Cox says. Unlike 10 years ago, though, he expects them to rise more slowly.

Risk tip: Informed refusal

More adults are exercising their right to refuse testing and treatment options. Documentation of those patients' refusal is the key to minimizing your risk exposure.

While patient refusal of procedures or tests doesn't equate with incompetence, refusal to comply with recommendations can be an important cautionary flag.

Physicians are encouraged to take a close look at their recommendations and at the reasoning behind a patient's refusal to follow them.[1]

In the legal case *Truman v. Thomas* in 1980, the California Supreme Court held that physicians are responsible for making sure patients are aware of all significant risks that could result from noncompliance.

This responsibility can include sending a letter outlining the risk of refusal to the patient; using "teach-back," a communication technique that allows patients to retell what the consequences will be if treatment is not followed; and maintaining an ongoing dialogue to find out the patient's reasoning.

Physicians' obligations apply equally to all tests and procedures, whether they are simple and routine or unusually complex. Physicians should also be concerned with patients who want to "bargain shop" for medications, medical equipment and supplies. Follow-up with patients is essential to ensure that they have adhered to physicians' advice. The obligation also applies to recommendations that a patient see a specialist, holding that physicians must inform patients of the possible consequences of not getting a consultation.

Documentation of refusal in a patient's medical record should include the following notations:

- Information that the physician gave the patient concerning his or her condition and the proposed treatment or test. Reasons for the treatment or test should be noted;
- Patient was advised of the possible risks and consequences of failing to undergo treatment or a test;
- Physician's referral of the patient to a specialist, including the reasons for the referral and possible risks of not seeing the specialist; and
- Patient's refusal of the physician's treatment/testing plan or advice. In this circumstance, consider asking the patient to sign a specific refusal-of-treatment form. These forms may be available through your professional liability carrier. Although the form is optional, it offers the strongest protection against claims alleging a lack of informed consent.

join the discussion: How have you reduced your practice's risk exposure? Tell us at mgma.com/connexioncommunity or connexion@mgma.com.

Notes

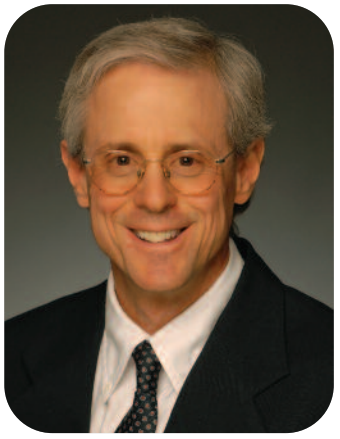
Lofsky AS, The High Cost of Losing Your Cool. The Doctors Advocate. Fourth Quarter, 2006. thedoctors.com/KnowledgeCenter/Publications/TheDoctorsAdvocate/CON_ID_000548 Accessed Aug. 2, 2010.

By Susan Shepard, MSN, MA, RN, CPHRM, director, Patient Safety Education, The Doctors Company, Napa, Calif., sshepard@thedoctors.com

THEFT

in group practices costs billions of dollars annually

Warning: New MGMA research shows that "honest" employees embezzle



By Denise McClure, CPA, CFE, president of Averti Fraud Solutions LLC, denise@avertifraudsolutions.com, with data analysis by James Margolis, MPA, FACMPE, MGMA, jwm@mgma.com

Given the choice to increase revenues by 5 percent or lose millions – or billions – to fraud, what would you do?

It is a choice, yet few professionals recognize it. As a result, medical practices lose $25 billion annually, according to the Association of Certified Fraud Examiners (ACFE). The group estimates that the typical organization loses 5 percent[1] of its revenues to fraud each year. Apply that number to the 2008 national physician and clinical services expenditures[2], and it becomes $25 billion.

In the 2010 ACFE report, 86 percent of perpetrators were first-time offenders[3] who had never been charged or convicted of a fraud-related offense.

MGMA members are not immune, according to Association research of 946 respondents conducted in November and December 2009.

MGMA members reported 782 cases of theft totaling $94,603,779 in losses. In these cases, employees stole through theft of receipts, cash on hand, disbursements such as forging or altering a check, submitting fictitious invoices, paying personal expenses with company funds, payroll and expense reimbursement. (See table on page 41.)

Although employee theft of $100,000 or more represented 18 percent of the cases, those high-dollar thefts accounted for 93 percent of the total losses. (See table on page 42.)

In one case, an accounts payable clerk stole $240,000 from a small group (fewer than 10 physicians) in a little over a year. He altered checks to legitimate vendors to make them payable to him. It was discovered by accident, as is often the case with embezzlement, while someone was looking for supporting documentation for a fixed-asset purchase.

How they do it

Employees who stole money worked alone in the vast majority of cases. In more than half the cases, employees had three or more years of tenure.

Most fraud schemes go undetected for long periods. In the MGMA research, it was a median of eight months compared to 18 months for the ACFE survey; however, thefts greater than $100,000 were ongoing for a median of 36 months[4] before being discovered.

Eighteen respondents reported losses of $1 million or more. The million-dollar schemes involved groups ranging from one to several thousand physicians.

One of the cases involved the administrator of a group of fewer than five physicians. For 20 years the person had control of all accounting functions with the exception of month-end financial reports prepared by an outside public accounting firm. The practice lost $1 million over five years through various payroll and cash disbursement schemes. It came to light when the administrator's husband was hospitalized and an outside person was brought in and quickly uncovered the scheme.

Many fraud schemes require constant attention to hide the losses. Any one of the following three internal controls may have prevented or diminished the theft described above:

1. Requiring the employee to take vacations while someone else covers his or her primary responsibilities;

see **Theft**, page 40

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MGMA's key research results

- Median loss: $5,000
- Median duration: eight months; 17 percent of thefts went undetected for more than two years
- High-dollar thefts of $100,000 or more accounted for 93 percent of the total losses reported, went undetected for three years and 81 percent involved only one perpetrator
- Two of three thefts of $50,000 or more involved medical groups of 10 or fewer physicians
- Top management perpetrated the theft in over half the cases where the loss was $50,000 or more
- Groups of 10 or fewer physicians accounted for 70% of the cases reported and 63% of the amount stolen; more than half the cases involved groups of five or fewer physicians