Getting Paid for Relationships

By Elizabeth Woodcock, MBA, FACMPE, CPC

Physicians have long expressed frustration at the lack of payment associated with the preparation time required to learn about a patient, develop insight about a patient, and nurture a relationship with the patient, all with an eye to being able to provide the highest quality care. While it may not be sufficient to reimburse for all your time, the new CPT® code for Medicare, G2211, is aimed to acknowledge the effort related to building longitudinal relationships.

The CPT® code description “Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).”

The national payment rate is slightly higher than $16. While certainly not a significant payment, consider it a boost to your Medicare office visit reimbursement. The Centers for

Medicare & Medicaid Services (CMS) estimates that it will be used with 38% of office visits. If you're already doing the work, it's certainly worth your time to learn more. See the FAQs for more information – and look for additional guidance from CMS in the coming months, as there are many questions that remain unanswered.

G2211 FAQs

Q: What is the implementation date for use of G2211?
A: When medically appropriate, the code may be used with dates of service beginning January 1, 2024

Q: When is it appropriate to use G2211?
A: Physicians may bill this code in conjunction with an office visit when they have an ongoing or long-term relationship with a patient who has a serious or complex medical condition.

Q: Are there exclusions?
A: G2211 cannot be billed with -25 modifier or 99211

Q: Do I bill it alone?
A: G2211 is an add-on code, to be billed in addition to an E/M code

Q: Is this code just for primary care providers?
A: No, it can be billed by any physician based on the relationship with the patient. CMS provides examples, including: "The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious disease physician must weigh their response during the visit—the intonation in their voice, the choice of words—to not only communicate clearly that it is important to not miss doses of HIV medication, but also to create a sense of safety for the patient in sharing information like this in the future."

Risk Matters: Curbside Opinions

By Jeffrey A. Woods, JD

The term "*curbside consultation/opinion"* is often used to describe an informal opinion or interpretation between colleagues that does not result in a "formal" consultation. Curbside consultations are transient in nature and typically occur in the hallway, break room, golf course, etc. often beginning with "Hey, let me run something by you." In most cases, the physician who is "consulted" has no intention of becoming involved in the patient's care, billing for services, or having their identity documented in the record. They also have no reasonable expectation of becoming involved in a claim or lawsuit due to this informal discussion. Unfortunately, when the curbside opinion is used to make or confirm treatment decisions, and a claim or lawsuit is subsequently asserted related to those decisions, the identity of the colleague who provided the informal consultation may be revealed because it can often strengthen the defendant physician's defense. Consequently, the consulting physician may be deposed and then potentially brought into the lawsuit and exposed to potential liability.

The best advice for physicians who participate in an informal consultation is to establish the following at the outset:

1. They are not being formally consulted
2. They do not have all the facts or the benefit of examining the patient
3. They have not reviewed the records
4. Their opinion or interpretation is general in nature and does not apply to any specific patient.

They should also confirm that this discussion is “strictly off the record”. While consistently establishing these parameters as part of the communication won’t guarantee that the consulting physician will never be exposed to potential liability, it does provide them with a basis for a defense later, if needed.

SVMIC Launches New Compliance Center

By Leslie L. Snider, MS, FACMPE, CHC, RT(R)

Medical practices face a myriad of challenges every day and need effective, efficient practice staff training. It is imperative that physicians, practice executives and staff understand their responsibility in remaining compliant in the ever-changing healthcare industry. With that in mind, SVMIC has developed a new, convenient approach to allow practices to provide online compliance education while meeting annual training requirements.

SVMIC is proud to launch our Compliance Center which features seven new courses related to medical practice compliance including HIPAA, OSHA, Compliance, and Ethics (Fraud Waste and Abuse), and three Cybersecurity modules. The online course options allow employees to take the course individually or watch as a group, in the comfort and convenience of their own office.

Please join us for the informational webinar January 24th at 9 AM CST or January 31st at 2 PM CST to learn more about this new tool for practice executives. You can register for the free webinar here. To view the Compliance Center, log into your Vantage® portal.

As always, SVMIC is available to answer any questions you may have and assist you in

your medical practice needs; we can be reached by phone at 800.342.2238 or by email at ContactSVMIC@svmic.com.

Decisions and Documentation

By John T. Ryman, JD

The patient was a 68-year-old female with a complicated medical history including significant cardiovascular disease and multiple previous surgeries. The events that are the subject of this case started in early 2014 when she was taken to surgery by Dr. Baker[i] for robotic salpingectomy, oophorectomy, transobturator sling, and robotic sacral colpopexy. The patient initially did well following this surgery.

About three months after the surgery, she presented to the ER with complaints of abdominal pain. She was given a GI cocktail and discharged after improvement of symptoms. The following day she presented to the ER with abdominal pain, nausea, and vomiting. A CT scan was interpreted as showing high-grade small bowel obstruction with possible internal hernia. The patient was admitted, and general surgeon Dr. Able was consulted that evening. On exam the patient's abdomen was soft, without guarding or distention. Dr. Able concluded that there was a high-grade small bowel obstruction and recommended conservative therapy. Later that evening, the patient was seen by Dr. Davis who noted that nausea and vomiting had improved.

The next day Dr. Able saw the patient and found her abdomen to be soft and non-tender without guarding or rebound tenderness. She remained hospitalized, and when Dr. Able saw her the following day he again found her abdomen to be soft and non-tender. The patient reported that she felt better. Dr. Able saw the patient again early the next morning and found her symptomatically better and without pain after two bowel movements. Her abdomen was soft and non-tender. Her white blood count had fallen. Dr. Able started her on clear liquids. The following day abdominal films had improved with nonspecific findings. She had multiple bowel movements, and her abdomen was soft and non-tender. The patient was started on a regular diet, and she tolerated breakfast and lunch. It appeared that her bowel obstruction had resolved, and she was discharged.

Two days later the patient presented to the ER with new, severe abdominal pain. Abdominal films were nonspecific. A CT scan was done which showed a partial small bowel obstruction with thickening of small bowel loops in the pelvis, somewhat improved since the previous CT. She was admitted without obtaining a surgical consult. The following day Dr. Baker noted that the patient was minimally arousable. She had moderate lower abdominal tenderness with guarding. Dr. Baker consulted with general surgeon, Dr. Charles, who ordered an NG tube which could not be placed initially and was later placed by interventional radiology. The patient's white blood count and lactic acid were elevated. Dr. Charles found the patient's abdomen to be soft and mildly tender. He planned to continue NG suction with surgery as an option if the patient's condition did not improve. Early the next day, Dr. Able found the patient had a mildly tender abdomen and she was sedated. Dr. Baker saw her later that morning and noted that the white blood count had risen to 18,000 the previous day with low urine output. A repeat white blood count had fallen significantly. A hospitalist later found the patient had a tender abdomen, was lethargic, and in severe sepsis and shock. The patient was transferred to ICU. Shortly thereafter, the patient became hypotensive and unresponsive. Dr. Able took the patient to surgery where she promptly arrested and was resuscitated. Dr. Able proceeded with surgery. He found a strangulated internal hernia related to a pelvic mesh band, with full thickness infarction and perforation. He removed 100cm of small intestine and did a small bowel anastomosis. The patient was treated aggressively in intensive care but died within 24 hours of surgery.

Approximately one year after the patient died, the patient's estate filed a lawsuit against the hospital, Dr. Able, Dr. Charles, and their group. With multiple ER presentations, a multi-day hospitalization, and ultimately the death of the patient, this was a challenging lawsuit. The lead up to trial was painfully long. Approximately nine years after the patient died this case went to a jury trial. Both the plaintiff and the defendant doctors had experts to support their positions. At the conclusion of that four-day trial, the jury faced the question of whether Dr. Able and/or Dr. Charles deviated from the standard of care in treating the patient. The jury found that they did not.

Winning at trial is always good news. What lessons can we learn from the successful defense of this case?

This is a classic case where there are multiple decision points during the patient's treatment, and there is an unfortunate outcome. In these cases, evaluation of the professional judgment of the doctors will be the focus of the trial. It can be difficult to know what the providers were thinking, and hindsight bias can be a problem. Hindsight bias is the tendency, upon learning an outcome, to overestimate one's ability to have foreseen the outcome[ii]. It is a cognitive bias sometimes referred to as the "I knew it all along phenomenon". Interestingly, it seems some of the early research in the 1970's on this common bias was related to the tendency of doctors to retrospectively overestimate the accuracy of their predictions of patient outcomes. We are all susceptible to hindsight bias, and it can be difficult to overcome. In medical cases hindsight bias may cause patients, family members, plaintiffs' attorneys, expert reviewers, and jurors to view the inevitability of the bad outcome as obvious. In real-time the outcome was unpredictable but seems easily predictable in hindsight. It is usually not difficult for the plaintiff to find an expert who will be critical of the decisions. It is easy for someone to look back with knowledge of the outcome and criticize the actions of the provider as being unreasonable. The bad outcome probably strengthens the bias toward criticism.

Healthcare providers are not required to be perfect but to use reasonable diligence and their best judgment. So, nine years after the patient's treatment how would one convince a jury that the provider's judgment was reasonable? The people evaluating the medical care are probably burdened with hindsight bias. Hopefully, support for the medical decisions is found in the medical record documentation.

I have written in a previous edition of the Sentinel (September 2023) about the importance of effective communication. In a case such as this one, documentation might be thought of as "communication with the future." This is communication with future medical providers, potential plaintiffs, plaintiff's attorneys, and plaintiff and defense experts. Good documentation tells what you saw and what you did. Great documentation also tells why. It shows your decision-making process. Quality, timely documentation makes it much easier to demonstrate that you were diligent and reasonable in your professional judgment.

When you first learn that a claim is being asserted against you, when someone is questioning the reasonableness of your judgment, it is unnerving. You will be anxious. Everyone is. If you review your documentation, and you find that it is complete, timely done, and shows what you were thinking, it will make you feel much better. So, when documenting treatment, one of the people you may be communicating with is your future self. A word of caution is appropriate here. If you later realize your documentation is less complete than you would like, you should not supplement or amend. Doing so usually will not help and may seriously impair your defense, or even jeopardize insurance coverage.

In this case there was good documentation by both defendant doctors. In depositions and at trial, they were able to clearly explain the decisions that they made, and help the jury

understand the reasonableness of those decisions. At the end of the trial the jury essentially found that both doctors were diligent and reasonable in their treatment of the patient, and they had no liability for the patient's death.

[i] All names have been changed.

[ii] Encyclopaedia Britannica
