Using Secure Portals for Patient Test Results

By Jeffrey A. Woods, JD

In last month's article, we discussed how better patient communication can help prevent missed appointments and improve follow-up. One of the safest and most convenient methods of communication with established patients is a portal. A patient portal is a secure online website that gives patients 24-hour access to personal health information. In addition to the benefits of security and convenience, portals allow patients to take "ownership" of their healthcare by taking a more active role. Other benefits include enhanced documentation of communication with a patient in the medical record and improved continuity of care as communication among multiple providers is likewise improved as they can easily review prior communications between the other providers and the patient. During the COVID-19 pandemic, portals can play an even more important role as they allow physicians and staff to work remotely while providing care to the patient using real-time information. Portals promote efficiency by reducing the amount of time expended in telephone interaction, medication refills, mailing appointment reminders, etc. A great deal of the staff's and provider's time is wasted each day playing phone-tag with

patients or family members. A portal can help eliminate this wasted time.

As reported in the national news this year, patients (including the parents of minor children) have expressed reluctance to schedule appointments for routine vaccinations and flu shots because they are afraid of exposing themselves and their children to COVID-19 in the physicians' offices. The portal is an excellent tool to communicate to existing patients the steps the practice is taking to reduce the likelihood of exposure to COVID-19 and to remind them of the importance of maintaining schedules and, especially this year, getting a flu shot.

A question we are frequently asked at SVMIC is, "Can normal test results be communicated to the patient via the portal?" The answer is a qualified "yes." It is qualified because certain requirements must be met in order to protect the provider.

Every practice should have a consistent method for notifying all patients of all test results and instructing them to call the practice if they have not received the results within the expected time frame. These instructions to the patients, as well as the actual patient notification, should be documented in the medical record. Although instructing the patient to call for test results does not absolve the doctor of the duty to inform the patient, it does act as an additional safety net to ensure that important test results do not get overlooked and is a legitimate means of involving the patient in his or her own healthcare. The more layers of redundancy that can be built into a system, the better.

Practices can make use of electronic patient portals for notification of normal, non-sensitive test results for those patients who have signed a written consent or electronically agreed to receive information via the portal, provided the patient has accessed the portal on at least one previous occasion. However, it is not reasonable to assume all patients are able or choose to use the portal. Practices should have a means of verifying that patients have accessed the portal before utilizing it as the sole vehicle of notification of normal, non-sensitive results. In other words, before sending normal non-sensitive test results to patients using the portal, the provider must first determine that, **at some time the past,** the patient has accessed information using the portal.

Patients who have not used the portal previously should be notified of normal test results through another means. It is not acceptable, from a risk or customer service perspective, to advise patients that the only method of normal non-sensitive test notification available will be through the portal.

Any patient with an abnormal test result, a report that contains sensitive information (i.e. pregnancy tests, STD tests, etc.), or a result requiring immediate action should be personally notified, and those results should not be posted to the portal prior to patient notification. Additionally, if the abnormal results include potentially serious or unanticipated consequences, the results should be communicated directly to the patient by the provider rather than a staff member. The notification to the patient should be documented in the EHR.

If you have any questions about the use of a portal or other risk-related issues, please

contact SVMIC at ContactSVMIC@svmic.com or 800.342.2239.

Mandatory Electronic Prescribing for Controlled Substances (EPCS) Effective January 1, 2021

By Julie Loomis, RN, JD

Most prescribers are aware of the upcoming requirement for Electronic Prescribing of Controlled Substances (EPCS) as mandated by the federal SUPPORT Act of 2018 and effective January 1, 2021. Primarily, this federal mandate affects Medicare Part D EPCS. In addition to the federal law, many states have new or existing EPCS laws (please see the table below). These are in line with the federal mandate but apply to ***all controlled substances*** regardless of payor.

The Drug Enforcement Agency (DEA) requirements for EPCS include two-factor authentication, which means prescribers who already issue electronic prescriptions, but whose systems are not EPCS certified, may need to work with their vendor to meet the DEA requirements. Prescribers without electronic health records or electronic prescribing

capability can find standalone software, available at minimal to no cost, for EPCS to use with a computer, tablet or smartphone. SVMIC strongly encourages prescribers to take the appropriate steps now to ensure compliance with federal or state EPCS mandates. Failure to do so may result in penalties, including licensure board referral and fines. Although the Centers for Medicare & Medicaid Services (CMS) EPCS mandate could be delayed, prescribers subject to state EPCS laws will be required to comply with such laws unless the prescriber meets licensure board exemptions or waivers.

Additional information regarding EPCS requirements and exemptions allowed can be found at the following links:

State	Has state law applicable to all payors?
Alabama	No
Arkansas	Yes - NEW!
Georgia	No
Kentucky	Yes - NEW
Mississippi	No
North Carolina	Yes
Oklahoma	Yes
Tennessee	Yes - NEW!
Virginia	Yes

IMPORTANT UPDATE NOVEMBER 30, 2020

Tennessee has issued the waiver form for ECPS. A health care prescriber that is unable to comply with the electronic prescription requirement for a Schedule II, III, IV or V prior to January 1, 2021, may apply for a waiver from the requirement based on economic hardship or technological limitations that are not reasonably within the control of the health care prescriber or other exceptional circumstance demonstrated by the health care prescriber.

Download the waiver form here.

Closed Claim Review: Opie and the Bully

By John T. Ryman, JD

> "I don't want him to be the kind of boy lookin' for fights, but I don't want him to run from one when he's in the right" – Sheriff Andy Taylor, The Andy Griffith Show, Opie and the Bully (1961)

Once upon a time in the fictional hamlet of Mayberry, young Opie Taylor had a problem. A local bully was confronting Opie on his journey to school each morning and demanding that he relinquish his milk money, or he would "get it". After some time, considerable anguish, and wise counsel from his father, Sheriff Taylor, Opie grew weary of this harassment and made a stand. It was a difficult, mentally and physically painful episode that earned Opie a black eye. He also retained his milk money and his honor. The bully was no longer a threat to him. If you grew up watching The Andy Griffith Show, you saw multiple incidents of our friends in Mayberry having to confront bullies. Sheriff Andy Taylor and his deputy, Barney Fife, had to confront and overcome challenges by bullies. Here in

the real-world life is not always idyllic and many of us have had to deal with bullies at times.

In this article, I am deliberately brief on the medical facts of the case. The conceptual lessons deserve the emphasis. The lessons are not unique to the facts of this case. The lawsuit originated as the result of a very common surgery. There were complications, which were promptly addressed and within the range of known complications for the procedure. A poor outcome does not equate to negligence, and there was none in this case. Unfortunately, the patient had some permanent injury. Our doctor was an excellent and well-respected surgeon. She deeply regretted that the patient had a poor outcome but recognized that it was not a consequence of any negligence on her part. She had done her best.

At mediation, which was ordered by the Court, the doctor declined the invitation to settle the case. This was of course unacceptable to the plaintiff and his attorney. The patient's attorney aggressively explained in detail how he would publicize any negative jury verdict if the doctor insisted on going to trial and lost. The doctor was shown examples of the full-page ads that would be run in the local paper to sensationalize the plaintiff's verdict. This was a small town, rather like Mayberry. Everyone would know. The doctor, recognizing that she had done nothing wrong continued in her refusal to settle the case. We, of course honored and fully supported the doctor's decision. However, the patient's attorney was intent on getting a settlement or making the doctor very uncomfortable.

In litigation, most attorneys are professional and zealously represent their clients within the bounds of civilized and ethical behavior. Some are more zealous than others. In the Preamble to the Tennessee Rules of Professional Conduct we find the following guidance for lawyers. "These principles include the lawyer's obligation zealously to protect and pursue a client's legitimate interests, within the bounds of the law, while maintaining a professional, courteous, and civil attitude toward all persons involved in the legal system." "As a negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others." "A lawyer should use the law's procedures only for legitimate purposes and not to harass or intimidate others." The rules are similar in most states.

The American Psychological Association defines bullying as "a form of aggressive behavior in which someone intentionally and repeatedly causes another person injury or discomfort. Bullying can take the form of physical contact, words, or more subtle actions." While the plaintiff's attorney in this case did not make a threat of physical injury, it was a threat to injure the doctor's reputation and practice. Injury to professional reputation is often a fear that doctors have in litigation. So, was this bullying? Was the action intended to advance an argument based on the facts and law or to intimidate the doctor into settlement? It was a threat intended to use the doctor's fear of public humiliation and possible damage to profession to encourage a settlement. One person's zealous advocacy is another's bullying. While we may disagree on whether this tactic amounted to bullying, the doctor certainly thought that it was.

If bullying tactics are used in your case, recognize them for what they are. Bullies use fear

and shame to try to control our actions. The plaintiff wants you to give up, to surrender and settle. Sometimes settlement is the wise and appropriate choice but be aware of why you decide to settle. Your defense attorney and claims attorney at SVMIC can help you evaluate that decision.

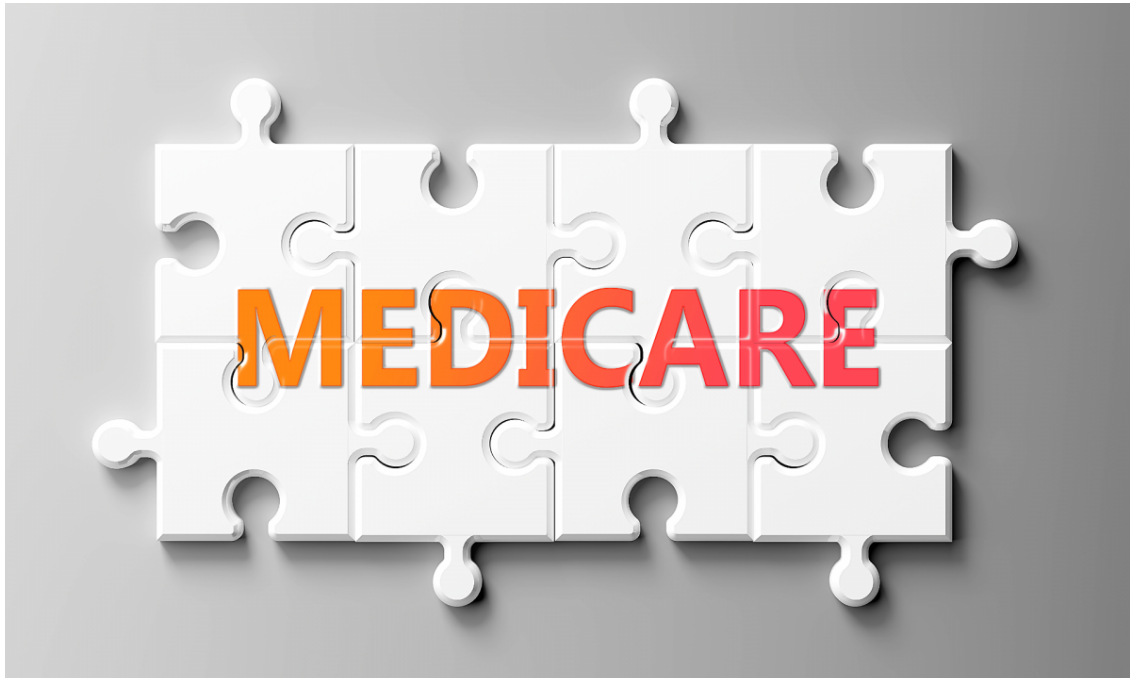
The doctor could have avoided much of the pain and uncertainty of litigation by insisting that we settle. It would have been easy for our doctor to back down and ask that we settle the case. However, this courageous doctor refused. The doctor was convinced that her care for the patient was appropriate and wanted to defend her care. “We can have courage or we can have comfort, but we cannot have both” – Brene Brown

What happened?

After a week-long trial the jury returned a verdict in favor of the doctor. The jurors unanimously agreed that she had complied with the standard of care, and therefore had no liability for the injury to the patient. This doctor probably felt the same fear and anxiety that Opie felt every morning on his walk to school, knowing he would have to face the local bully, and the possibility that he would “get it”. When the dust settled, it had been an unpleasant week in the arena, but she prevailed.

If you encounter bullying tactics in a lawsuit you might consider Opie Taylor and how he rose to the challenge and defeated the bully in his life. And remember we have your back.

QPP Exemption Application Open



By Elizabeth Woodcock, MBA, FACMPE, CPC

As the end of the year draws near, it is an opportune time to consider your participation in the Quality Payment Program (QPP). Launched by the Medicare Access to Care and CHIP Reauthorization Act (MACRA) in 2015, the QPP exacts mandatory participation from physicians and other eligible clinicians who meet certain thresholds related to Medicare. If you have $90,000 or more in Medicare Part B payments per year, you are subject to the program requirements. If you do not participate successfully, your 2022 payments from Medicare are penalized. In 2022, the penalty is a remarkably harsh 9%, applied to *all* Medicare reimbursement. Despite the current pandemic, there is no automatic relief from this government program.

That is the bad news; let us address the good news.

First, you can participate in the program as you may have in the past. Many medical practices have a great rhythm to the program – and are gung-ho to report in 2020 despite the chaos of the environment. If history serves as a guide, the bonus opportunity for "exceptional" performance will likely be 1 to 2%. The payment boost for the program's

exceptional performance threshold has been 1.88%, 1.68% and 1.79%, respectively, for each of the past three years. The percentage, which is added to your Medicare reimbursement in a future year, is determined based on the losses sustained by physicians who do not successfully participate, as the program is designated to be budget neutral. If you are in a position to achieve exceptional performance in 2020, go for it!

Second, you can get out of the program – and its dreadful penalty -- by submitting an exception application. You have two applications from which to select: the *Promoting Interoperability Performance Category Hardship Exception* and the *Extreme and Uncontrollable Circumstances Exception*.

The first application focuses solely on the "Promoting Interoperability" (PI) category, which is the old "meaningful use" program. If you are a small practice, which is defined as a tax identification number (TIN) with 15 or less eligible clinicians, you can apply simply based on your practice's size. Otherwise, a practice can apply if one or more of the following are applicable: decertification of EHR system; insufficient WiFi; uncontrollable circumstances such as severe financial distress; or no control over the availability of EHR system. You must apply in writing; it will qualify you for a re-weighting of the PI category to 0%. Once submitted, therefore, you need only be concerned with the QPP's three other categories.

The second application is broader in nature; it pertains to all four categories. Based on experiencing an extreme and uncontrollable circumstance – like COVID – you can apply to have one, two, three – or all four – categories of the QPP reweighted to 0%. If you apply for an exemption from all four categories, you no longer are required to report data. And, perhaps most importantly, you will *not* be penalized.

It is worth noting that there is one circumstance in which you do not need to apply. If your geographic location is inside a declared emergency area – e.g., the Federal Emergency Management Agency (FEMA) declares your locale an emergency zone – then your exemption will be automatic. We may have some strong hurricanes or tornadoes come through this fall to trigger this status; however, do not rely on this.

Other than this narrow exception, the exemption is not automatic; an application must be submitted. To apply, you will need:

- A HCQIS Access Roles and Profile (HARP) account
- Click on the "Exceptions Application" (left-hand navigation)
- Select "Extreme and Uncontrollable Circumstances"

You will be notified by email if your request was approved or denied.

Don't delay: the application is open. It takes only minutes to complete. **The government closes the application at 8 p.m. EST on December 31, 2020.** Better yet, should you change your mind and decide to report for the QPP, the government will waive your application. In other words, if you are approved for the exception, you can still choose to report. This fact makes the application a no-brainer; you're ensuring that you won't be

socked with the 9% penalty in 2020 but also leaving the window open to report if you change your mind

To apply – and for more details about the application process: https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2020.

Patient Financial Responsibility Didn't Go Away

There has been no shortage of challenges in 2020. Being on the frontlines of an unprecedented crisis has not left much time to think about your revenue cycle. As we move into 2021, it is important to recognize that the shift in patient financial responsibility has not slowed – in fact, it sped up. Therefore, you need to be prepared to collect from patients at the point of service – and throughout the collection cycle.

Let us understand first what *can* be collected. Medicare will continue to allow the use of the "-CS" modifier to waive the patient's responsibility for services at which a COVID test is rendered or ordered through the conclusion of the Public Health Emergency (PHE). (For more information, see the Families First Coronavirus Response Act.) Otherwise, you will still need to collect coinsurance and deductibles from Medicare beneficiaries. Unless you are in one of the handful of states that allow copayment collection from Medicaid, that is a patient population that can largely be ignored from a payment perspective.

Commercial payers, however, cannot be ignored. Their payment policies vary by plan. Some are allowing the responsibility for certain services – like G2012 (virtual check-in) for Cigna – to be waived, but there is typically an end date – like the end of October for Cigna. Outside of COVID-related testing and treatment, which Cigna and others are covering at the full allowable, commercial payers are transferring the financial responsibility to patients just as they did prior to the pandemic. This puts you at risk for financial loss should you not know about the collection – or pursue it.

With the movement to contactless registration and reception, it is vital to maintain your ability to collect from the patient under the new normal. Consider a multitude of points: display and request balances when an established patient logs on to self-schedule; push notifications about balances via your patient portal (and allow the patient to seamlessly pay online); transmit texts about payment due – and offer an easy link-to-pay option; and collect point-of-service payments via tablet or kiosk as patients register, as well as when they check-in and out of the office.

In sum, just as you ramped up your technology platforms for telemedicine, it is an opportune time to embrace technology to facilitate the patient payment process.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal

attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.